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# Insuring the Protection of ERISA Plan Participants: ERISA Preemption and the Federal Government's Duty To Regulate Self-Insured Health Plans

DENNIS K. SCHAEFFER†

## INTRODUCTION

In passing ERISA, Congress reserved to itself the power to regulate employee pension and welfare benefit plans.<sup>1</sup> Yet Congress focused the bulk of ERISA's substantive provisions on pension plans.<sup>2</sup> Indeed, the terms that comprise

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1. See The Employee Retirement Income Security Act of 1974 §§ 2(a), 514, Pub. L. No. 93-406 (1974) (codified at 29 U.S.C. §§1001(a) et seq.) (please note that in keeping with the majority of other scholarship concerning ERISA, citations to ERISA in this Comment refer to sections of the public law and not the U.S.C.) [hereinafter ERISA]; see also SUBCOMMITTEE ON LABOR OF THE HOUSE COMM. ON LABOR AND PUB. WELFARE, 94TH CONG., LEGISLATIVE HISTORY OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974, at 4760 (1976) ("pervasive Federal interest and the interests of uniformity with respect to interstate plans required—but for certain exceptions—the displacement of State action in the field of private employee benefit programs"); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981) (stating that ERISA was designed to "establish pension plan regulation as exclusively a federal concern.").

2. See Jeffrey Lenhart, *ERISA Preemption: The Effect of Stop-Loss Insurance on Self-Insured Health Plans*, 14 VA. TAX. REV. 615 (1995). Mr. Lenhart observes that "ERISA's substantive provisions are, for the most part, directed at employee pension plans, but the expansive scope of its preemption provision reaches employee welfare benefit plans as well." *Id.* at 618. Lenhart notes that regulations of these welfare benefit plans appear only in one of ERISA's four titles. Within that one title, welfare benefit plan provisions account for less than half of the substantive provisions. See *id.* at 618 n.15.; see also *Metropolitan Life Ins. Co. v. Massachusetts Travelers Ins. Co.*, 471 U.S. 724, 732 (1985) ("ERISA imposes upon pension plans a variety of substantive requirements relating to participation, funding and vesting. . . . [yet] ERISA . . . contains almost no federal regulation of the terms of [employee welfare] benefit plans."); New York State Conference of Blue Cross & Blue Shield Plans v.

the statute's acronym — "Employee Retirement Income Security Act" — evince a concern with the security of workers' pensions.<sup>3</sup>

Although Congress focused ERISA on employees' pension benefits, it failed to regulate employees' welfare benefit plans in a similarly comprehensive fashion.<sup>4</sup> Nevertheless, Congress imbued ERISA with a sweeping preemptive effect on state laws that concerned employee welfare benefit plans.<sup>5</sup> Congress' decision to place welfare benefit plans exclusively under ERISA's purview was due in part to corporate concerns over the confusing, complex and interstate nature of administering employee welfare benefits.<sup>6</sup> The federal government's combined action and inaction in this regard has caused employee welfare benefits to

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Travelers Ins. Co., 514 U.S. 645, 651 (1995) ("[ERISA] does not go about protecting [welfare] plan participants and their beneficiaries by requiring employers to provide any given set of minimum benefits, but instead controls the administration of benefit plans"). See generally Michael Gordon, *Overview, Why Was ERISA Enacted?*, in U.S. SENATE, SPECIAL COMM. ON AGING, THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974: THE FIRST DECADE 21-29 (1984). Mr. Gordon notes that the origins of ERISA can be traced to the 1960s, when the public became increasingly concerned with alleged widespread mismanagement and underfunding of pensions. See *id.* at 22.

3. ERISA defines pensions as plans that provide income deferral or retirement income. 29 U.S.C. § 1002(2). ERISA primarily regulates pensions. See ERISA, *supra* note 1 and accompanying text. ERISA, however, does not regulate all pensions equally. By far the most heavily regulated type of pension is the "defined benefit" pension. See ERISA: A COMPREHENSIVE GUIDE 31-32 (Martin Wald and David E. Kenty, eds., 1991) [hereinafter ERISA: A COMPREHENSIVE GUIDE]. The fact that ERISA is focused on "defined benefit" plans would seem to indicate that the law was meant to create security for workers who rely on traditional pension benefits.

4. See, e.g., *Met Life*, 471 U.S. at 732.

5. See ERISA § 514(a) ("the provisions of this title and title IV shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . ."); *id.* § 3(1) ("[t]he terms 'employee welfare benefit plan' and 'welfare plan' mean any plan, fund or program . . . maintained by an employer . . . for the purpose of providing . . . medical, surgical or hospital care or benefits . . ."); *Met Life* 471 U.S. at 726 (1985) ("The phrase 'relate to' was given its broad common-sense meaning, such that a state law 'relate[s] to' a benefit plan 'in the normal sense of the phrase, if it has a connection with for reference to such a plan,' (quoting *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 97 (1983)).

6. See *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46 (1987) ("[ERISA is] intended to preempt the field [of employee benefit plans] for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans."); see also *Northern Group Serv., Inc. v. Auto Owners Ins. Co.*, 833 F.2d 85, 88 (6th Cir. 1987).

experience a "regulatory vacuum."<sup>7</sup> The situation is properly characterized as a "vacuum" because ERISA prohibits states from regulating employee welfare benefit plans in spite of federal silence on the matter.<sup>8</sup> The regulatory vacuum surrounding welfare benefit plans has come at the expense of the participants and beneficiaries of those welfare benefit plans. Take the following example:

A delivery truck hit Don Thompson, a twelve year-old boy from rural Virginia, while he was riding his bike along a country road. Don's injuries are not life threatening. Don is fortunate because his father works at the local mill and, through his employer, participates in a group health care plan. Furthermore, Virginia State law requires insurance companies to provide coverage for injuries arising out of an auto accident in all of their group health care plans. It would appear that Don and his family are covered for the costs of treating his injuries.

However, the mill did not buy its medical insurance from a third party insurance company. Instead, it has "self-insured" its health care plan. ERISA preempts the pertinent Virginia law from applying to the employer's health care plan. The employer's health care plan, fully aware of ERISA's preemptive effect, has excluded coverage for injuries sustained in connection with an auto accident.

For its part, ERISA does not address whether an employee welfare benefit plan must provide such coverage. Due to ERISA's preemption of Virginia's law and its silence on the issue, Don's family will be liable for \$63,000 in medical bills.<sup>9</sup>

The above scenario is but a leading example in a parade of horrors; a parade that continues to be a subject of debate.

This Comment addresses a few of the many issues that

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7. Fox and Schaffer, *Health Policy and ERISA*, 14 J. HEALTH POL. POL'Y & L. 239, 240 (1989). See also Catherine L. Fisk, *The Last Article About the Language of ERISA Preemption? A Case Study of the Failure of Textualism*, 33 HARV. J. LEGIS. 35, 36-39 (1996) (arguing that ERISA's broad preemptive effect is odd because as law that is intended to provide significant federal protection, ERISA instead has created a regulatory vacuum by invalidating numerous state regulations).

8. *Id.*

9. See *Thompson v. Talquin*, 928 F.2d 649 (4th. Cir. 1991).

underpin the current problems surrounding federal and state regulation of employee health care plans. The analysis begins by providing a brief overview of the genesis and scope of the Employee Retirement Income Security Act. Furthermore, the Comment addresses the ways in which judicial interpretation has led to ERISA having a powerful preemptive effect on state law. The Comment then offers both historical and present-day perspectives on how employers use certain insurance mechanisms (namely "self-insurance" and "stop-loss insurance") as methods to avoid state regulation. By utilizing these techniques, many employers have capitalized on ERISA's preemption of state laws; laws that would otherwise regulate, albeit indirectly, employee welfare benefit plans. This Comment will also analyze the ways in which the circuit courts have responded to employers' efforts to evade state regulation. Notably, the majority of the circuits have validated employers' efforts to capitalize on ERISA preemption through the use of certain insurance techniques.

The irony of this situation is that Congress, in passing ERISA, simultaneously acknowledged the need for states to regulate the substantive terms of *certain* employee welfare benefit plans and denied that there was a need for states to regulate the substantive terms of *other* welfare benefit plans.<sup>10</sup> The Comment concludes that the relevant case law and ERISA's language will prohibit the states from regulating employers that self-insure their welfare benefit plans. The Comment calls for federal intervention, noting that the federal government has an affirmative duty to address this situation through comprehensive and reasonable regulation of employee welfare benefit plans—a responsibility that ERISA has prevented the states from assuming.

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10. What is referred to here is the different ways in which ERISA treats employee welfare benefit plans that are insured traditionally through a third-party insurance provider and the ways in which ERISA treats employee welfare benefit plans that are "self-insured" or "self-funded." See *infra* Parts III and IV; THE NEW YORK STATE HEALTH ADVISORY COUNCIL & THE NEW YORK BUSINESS GROUP ON HEALTH, SELF-INSURANCE & HEALTH CARE BENEFITS IN NEW YORK STATE: AN EXPLORATORY STATEMENT AND DESCRIPTIVE ANALYSIS 55 (1982) [hereinafter STATE HEALTH ADVISORY COUNCIL].

## I. BACKGROUND: ERISA'S SWEEPING PREEMPTIVE EFFECT

America's Labor movement and the general public's fear over alleged corporate mismanagement of employee pension funds motivated Congress to draft and pass ERISA in 1974. The seminal incident that sparked ERISA's passage is known as the "Studebaker Incident."<sup>11</sup> Studebaker, the automobile manufacturer, closed a plant in South Bend, Indiana in 1963. After the plant closed, it was revealed that the plant's pension fund could not cover the pensions of nearly seven thousand former Studebaker employees. This shortfall caused many of these workers to lose most, if not all, of their anticipated pension benefits.<sup>12</sup> The Studebaker Incident pushed the issue of securing employee benefits into the national spotlight, and set the stage for ERISA's eventual passage.<sup>13</sup>

ERISA imposed heavy regulatory burdens on employers. As a result, Congress passed ERISA in spite of resistance from corporate America.<sup>14</sup> Perhaps in response to

11. See Michael Allen, Memorandum, *The Studebaker Incident and Its Influence on the Private Pension Plan Reform Movement*, in PENSION AND EMPLOYEE BENEFIT LAW 62-65 (John H. Langbein and Bruce A. Wolk, eds., 1995).

12. Prior to ERISA, employers generally retained the right to revoke accrued pension benefits. See Norman P. Stein, *Reversions from Pension Plans: History, Policies, and Prospects*, 44 TAX L. REV. 259, 279-80 (1989). Employers usually characterized pension benefits as gifts. See *id.* The Studebaker employees, then, had no recourse when the funding for the pension trust expired.

13. See *id.*

14. See, e.g., A&P HEARINGS H.R. 10470, at 261-63 (Oct. 12, 1973). This collection of legislative history contains a letter from Larry Brown, Chairman of Canton's Congressional Action Committee. *Id.* at 265. Mr. Brown addressed this letter to John M. Martin, Jr., Chief Counsel for the Committee on Ways and Means. *Id.* Mr. Brown communicated the following concerns with federal regulation of employee pensions:

We oppose:

1. Any change that would impose a self-employed contribution limit on qualified corporate pension plans.

2. Additional funding requirements with no consideration of increased costs.

3. Too early vesting, which will encourage "job hopping" and invalidate one of the original purposes of private pensions to retain employees.

4. Portability; adequate vesting makes this academic. Also, it is costly and would ultimately lead to lower benefits.

5. *Giving Federal administrative officials added power to regulate or interfere in the management of private pension plans in the absence of a proven need for such additional powers.*

*Id.* (emphasis added).

these corporate concerns, Congress incorporated certain concessions into ERISA. The principal concession to business interests was ERISA's preemption clause — section 514(a). Section 514(a) was intended to reduce the administrative costs and headaches associated with running employee welfare benefit plans.<sup>15</sup>

Prior to ERISA, business interests complained about how difficult it was to deal with conflicting state regulation of pension and welfare benefit plans.<sup>16</sup> Corporate lobbyists insisted that this patchwork system of regulation placed unmanageable burdens on personnel managers and systems.<sup>17</sup> Business interests also bemoaned the difficulties of coordinating employee benefit plans across state lines; inevitably there were "divergent regulatory schemes in different states."<sup>18</sup> These lobbyists encouraged the federal government, through ERISA, to make regulation of employee benefits exclusively a federal matter.

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15. As will be discussed throughout the Comment, ERISA preemption eliminated the problem that flowed from the states' disparate and often conflicting regulation of employee benefit plans. *See supra* note 6 and accompanying text; *infra* note 18 and accompanying text.

16. *See supra* note 6 and accompanying text (containing citations to court cases that discuss the ways in which ERISA streamlined employers' administration of employee benefit plans).

17. *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46-47 (1987).

18. *See id.* Along these lines, Representative Dent has stated:

The most efficient way to meet these responsibilities is to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits. Such a system is difficult to achieve, however, if a benefit plan is subject to differing regulatory requirements in differing States. . . . [as a result ERISA's preemption provision must] ensure . . . that the administrative practices of a benefit plan will be governed by only a single set of regulations.

*Id.* (citing 120 Cong. Rec. 29,197 (1974)). *See also Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990).

[T]o ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government . . . [and to prevent] the potential for conflict in substantive law . . . requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction.

*Ingersoll-Rand*, 498 U.S. at 142; ERISA: A COMPREHENSIVE GUIDE, *supra* note 3, at 250.

## II. ERISA PREEMPTION OF STATE LAW

### A. Step One: The Preemption Clause

None of ERISA's provisions have created "more litigation or more confusion than ERISA's preemption provisions."<sup>19</sup> This confusion begins with the fact that the application of ERISA's preemption clause is a three-step process.<sup>20</sup> The first step in ERISA preemption analysis is to determine whether the state law falls within ERISA's general preemption clause.<sup>21</sup> This clause in ERISA preempts any state law that "relates to" an employee benefit plan.

In order to give effect to ERISA's goal of uniform regulation,<sup>22</sup> the Supreme Court has given this phrase sweeping effect.<sup>23</sup> The Supreme Court, as well as the circuit courts, have made it clear that ERISA will preempt state laws that refer to or are connected with employee benefit plans.<sup>24</sup> Certain courts have gone further and found that ERISA preempts state laws that have the purpose and effect of regulating employee benefit plans.<sup>25</sup> In addition, federal courts are also on guard for any "backdoor" attempts to regulate these benefit plans, and have stated a willingness to look beyond the form of state laws and to sift through a law's purpose and effect in order to uphold ERISA's policy of preemption.<sup>26</sup> In light of this judicial construction, then, the preemption clause absolutely prohibits any state encroachment into this realm of exclusive federal

19. ERISA: A COMPREHENSIVE GUIDE, *supra* note 3, at 244.

20. See ERISA § 514(a), (b)(2)(A), (b)(2)(B) (1992).

21. See *United Food & Commercial Workers & Employers Ariz. Health & Welfare Trust v. Pacyga*, 801 F.2d 1157, 1160 (9th Cir. 1986); *Tri-State Mach., Inc. v. Nationwide Life Ins. Co.*, 33 F.3d 309, 311 (4th Cir. 1994).

22. See *supra* note 18 and accompanying text.

23. See, e.g., *Metropolitan Life Ins. Co. v. Massachusetts Travelers Ins. Co.*, 471 U.S. 724, 739 (1985). See also *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981) (holding that "even indirect state action bearing on private pensions may encroach upon the area of exclusive federal concern").

24. See *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983); see also *Met Life*, 471 U.S. at 739; *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990).

25. See *American Med. Sec., Inc. v. Bartlett*, 111 F.3d 358, 363 (4th Cir. 1997).

26. See *Holliday*, 498 U.S. at 56. The court stated that ERISA's plain language required the court to "reach back-door attempts by states to regulate core ERISA concerns . . ." *Id.*



concern.

### B. *Step Two: The Savings Clause*

Congress followed the general preemption clause with the savings clause. While the general preemption clause takes power from the states, the savings clause gives power back to the states. Indeed, the savings clause was a broad return of power to the states.<sup>27</sup> The savings clause exempts from ERISA's general preemption clause the states' power to regulate the insurance, banking and securities industries.<sup>28</sup> With respect to insurance, the savings clause was consistent with a long-time federal policy on which industries should be state-regulated.<sup>29</sup>

Federal courts have inferred that Congress did not seek to usurp traditional areas of state authority through ERISA, and as a result have given the savings clause a broad construction—similar to the construction given to the general preemption clause.<sup>30</sup> Thus, sections 514(a) and 514(b)(2)(A) combine to produce equally extreme and contrary grants of power. Justice Blackmun has wryly remarked that "[t]he two preemption sections, while clear enough on their faces, perhaps are not a model of legislative drafting."<sup>31</sup> Justice Blackmun went on to observe that "[w]hile Congress occasionally decides to return to the States what it has previously taken away, it does not normally do both at the same time."<sup>32</sup>

### C. *Step Three: The Deemer Clause*

The process of evaluating whether a state law will

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27. See ERISA § 514 (b)(2)(A) (1992) ("Except as provided in subparagraph (B), nothing in this title shall be construed to exempt or relieve any person [or corporation] from any law of any State which regulates insurance, banking, or securities.").

28. See *id.*

29. See McCarran-Ferguson Act of 1945, 15 U.S.C. § 1011, et seq. (1992) (reserving to the states the exclusive right to regulate the insurance industry within their own respective sovereignties). "The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business." *Id.* § 1012(a).

30. See *Metropolitan Life Ins. Co. v. Massachusetts Travelers Ins. Co.*, 471 U.S. 724, 740 (1985).

31. *Id.* at 739.

32. *Id.*

survive ERISA preemption is further complicated by ERISA's deemer clause.<sup>33</sup> Once a court has decided that the general preemption clause preempts a state law, but that the savings clause protects that state law from general preemption (perhaps, for example, because the state law regulates the insurance industry), the court still must make yet a third ruling.<sup>34</sup>

In this third step, a court must discern whether the law has effectively "deemed" an employee benefit plan to be an insurance company or in the business of insuring.<sup>35</sup> The deemer clause, ultimately, will preempt valid state regulations to the extent that those regulations apply to or are intended to affect the administration of ERISA-regulated employee benefit plans.<sup>36</sup> The deemer clause, then, expands on the confusion noted by Justice Blackmun in *Metropolitan Life Insurance v. Massachusetts*.<sup>37</sup> That is, an analysis of the deemer clause yields the inference that "Congress appears to have taken away, returned, and again taken away from the states certain powers—all in the same statute."<sup>38</sup>

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33. See ERISA § 514(b)(2)(B) (1992) ("Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or . . . engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts . . .").

34. See *FMC Corp. v. Holliday*, 498 U.S. 52, 58-61 (1990) (discussing Pennsylvania anti-subrogation law that clearly "relates to" an employee benefit plan but also clearly is a regulation aimed at the insurance industry); see generally *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 127-129 (1982) (discussing generally how a court determines whether a state law actually regulates the insurance industry).

35. See *Holliday*, 498 U.S. at 61; *United Food & Commercial Workers & Employers Ariz. Health & Welfare Trust v. Pacyga*, 801 F.2d 1157, 1160 (9th Cir. 1986).

36. See *Holliday*, 498 U.S. at 62-64 (stating, among other things, "[w]e read the deemer clause to exempt . . . [employee benefit plans] from state laws that 'regulate insurance' within the meaning of the saving clause"); *Safeco Life Ins. Co. v. Musser*, 65 F.3d 647, 651-52 (7th Cir. 1995) (noting that "the Court in prior cases had deemed preempted state laws that had the effect of regulating the structure or administration of ERISA plans or providing avenues outside of the ERISA framework to vindicate employees' rights under these plans.").

37. See *Metropolitan Life Ins. Co. v. Massachusetts Travelers Ins. Co.*, 471 U.S. 724, 739 (1985).

38. See *Lenhart*, *supra* note 2, at 621.

## III. UNFORESEEN CONSEQUENCES OF ERISA

A. *States Suffer a Defeat—Was It Foreseen?*

Congress' enactment of ERISA and the courts' interpretation of it represented, among other things, a blow to the states and their efforts to regulate employee welfare benefit plans. The states, however, did not take this defeat lying down.

Certain scholars have argued that the health care and insurance industry experts did not anticipate this "defeat." According to this perspective, experts who *did* pay attention to ERISA's health care implications<sup>39</sup> acknowledged, at the time of passage, that ERISA would undoubtedly create serious regulatory gaps for employee welfare benefit plans. These experts speculated, however, that either federal regulations concerning employee welfare benefit plans or national health insurance would likely fill these gaps in regulation.<sup>40</sup> However, the years following ERISA's passage witnessed a combination of changes in the social, economic and political climate of America.<sup>41</sup> With these changes, hopes faded that new federal regulations would address the "regulatory gap."<sup>42</sup> These hopes were dashed altogether when President Carter's push for health care reform

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39. See Fox and Schaffer, *supra* note 7, at 243-244. The authors provide an illuminating look at the actual players in ERISA's passage. They note that other issues in the health care insurance industry occupied the attention of experts and analysts during the period of ERISA's adoption. See *id.* The authors quote a then employee of the Health Insurance Association of America, "I don't think anybody was thinking of the health implications of ERISA. Thus congressional staff and a few lobbyists made a major decision about employee benefits policy as if it were a technical issue." *Id.* at 244.

40. See *id.*

41. See generally Edward R. Crane, *The Reagan Record: Change, But Not Quite a Reagan 'Revolution,'* SAN DIEGO UNION & TRIBUNE, Jan. 15, 1989, at C5.

Mr. Crane noted in retrospect of the Great Communicator's career in office: The great achievement of Ronald Reagan, the one aspect of his eight years as chief of state [sic] that might be termed "revolutionary," was his remarkable ability to change the terms of political debate in America . . . In 1980 President Reagan ran an explicitly ideological campaign, and in so doing struck a responsive chord with the American electorate.

*Id.*; see also Fox and Schaffer, *supra* note 7, at 244-245.

42. Fox and Schaffer, *supra* note 7, at 244-245.

failed.<sup>43</sup> In fact, the late 1970s arguably marked the beginning of the end for the "American Welfare State."<sup>44</sup> The onset of "Reaganomics" brought massive federal deregulation to many industries, thus assuring that the states would be left to contend with the regulatory vacuum surrounding employee health care plans.<sup>45</sup> The states found that ERISA prevented them from stepping into the regulatory gap that ERISA had created.<sup>46</sup>

## B. Metropolitan Life Insurance v. Massachusetts<sup>47</sup>

To be sure, ERISA prevented states from directly regulating employee welfare benefit plans. Some states responded to this impasse by finding a way to get around ERISA preemption and fill regulatory gaps.<sup>48</sup> In 1985, Massachusetts passed a law<sup>49</sup> requiring insurance companies that sold general group health care policies to employers in Massachusetts to provide certain minimum benefits with those policies. The relevant section of the law, 47B, required insurance companies to provide minimum mental health care benefits to the beneficiaries of a group

43. See *id.* at 244.

44. See *id.*

45. See Rena Steinzor, *Unfunded Environmental Mandates and the "New (New) Federalism": Devolution, Revolution or Reform?*, 81 MINN. L. REV. 97 (1996). The author notes that President Reagan's program of deregulation included the goals of reducing the federal bureaucracy's bulk and deregulating public health. See *id.* at 113-14. The author went on to note:

By claiming to have the states' interest in more authority . . . and by promising to dismantle the federal bureaucracies that had stolen that authority, the administration created political cover for . . . rolling back regulation that its major industrial supporters found offensive.

*Id.* at 118; see also Fox and Schaffer, *supra* note 7, at 244-245.

46. See *supra* Part II (discussing scope and effect of ERISA preemption).

47. 471 U.S. 724 (1985).

48. See MASS. GEN. LAWS ch. 175, § 47B (1984); see also *infra* note 60 (noting other state laws mandating coverage for certain health care benefits).

49. See MASS. GEN. LAWS ch. 175, § 47B (1984); see also *Met Life*, 471 U.S. at 730 (noting that section 47B required health insurance policies to provide, among other things, minimum amounts of coverage for confinement in a mental hospital as well as minimum outpatient benefits). For another example of state-mandated benefit laws see STATE HEALTH ADVISORY COUNCIL, *supra* note 10, at 60. The report indicates that in New York, coverage mandates included: "(1) Home Health Care, (2) Maternity Care Coverage, (3) Pre-Admission testing prior to surgery, (4) Coverage of medical services provided in hospital facilities, (5) second Surgical Opinion, (6) Coverage in group policies of newborn infants from moment of birth." *Id.*

health care policy.<sup>50</sup>

Representatives from the insurance industry challenged the law, claiming that Massachusetts was regulating the insurance industry in this way only so that it could regulate the terms of employee benefit plans.<sup>51</sup> The plaintiff insurance companies also argued that the regulatory impact of section 47B did not fit within ERISA's savings clause because it was beyond the scope of "traditional"<sup>52</sup> insurance regulation as contemplated by the ERISA savings clause.<sup>53</sup> The Supreme Court rejected the insurance companies' arguments and found that Congress had intended the savings clause to operate as a broad exception to the general preemption clause.<sup>54</sup>

The court found that a proper reading of the savings clause required the conclusion that the savings clause "saved" state laws that directly regulated the substantive terms of insurance contracts.<sup>55</sup> The Court observed that state regulation of the substantive terms of insurance contracts was a "traditional" method of regulating insurance and as a result fell within the purview of ERISA's savings clause.<sup>56</sup> The Court conceded that states, as a result of this ruling, would be able to indirectly regulate the terms of employee benefit plans.<sup>57</sup>

Massachusetts' victory in the Supreme Court seemed to signal a clear victory for the states.<sup>58</sup> Whereas ERISA had

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50. See STATE HEALTH ADVISORY COUNCIL, *supra* note 10, at 60.

51. See *Metropolitan Life Ins. Co. v. Massachusetts Travelers Ins. Co.*, 471 U.S. 724, 741 (1985).

52. *Id.* at 741-42.

53. See *id.*; see also ERISA § 514(b)(2)(A) (1974) (savings clause).

54. See *Met Life*, 471 U.S. at 739-41.

55. See *id.* at 741. Justice Blackmun stated that:

[T]his distinction reads the savings clause out of ERISA entirely, because laws that regulate only the insurer, or the way in which it may sell insurance, do not 'relate to' benefit plans in the first instance. Because [such state laws] would not be pre-empted by § 514(a), they do not need to be 'saved' by § 514(b)(2)(A).

*Id.*

56. See *Metropolitan Life Ins. Co. v. Massachusetts Travelers Ins. Co.*, 471 U.S. 724 (1985), 742-743 (stating that a "regulation regarding the substantive terms of insurance contracts falls squarely within the saving clause as laws 'which regulate insurance.'").

57. See *id.* at 747.

58. See generally *id.* (allowing the states to accomplish through regulation of the insurance industry that which they could not accomplish through direct regulation of employee welfare benefit plans.).

apparently brought an end to state regulation of employee benefit plans; Massachusetts' section 47B, and other state laws like it,<sup>59</sup> signaled that states could indirectly regulate the nature and extent of health care coverage in ERISA-regulated benefit plans.

A recent count revealed that there are now over one thousand state-mandated benefit laws on the books of the several states.<sup>60</sup> State-mandated benefit laws have grown from forty-eight in 1970 to over one thousand in 1991—now “covering heart transplants in Georgia, liver transplants in Illinois, hairpieces in Minnesota . . . and sperm-bank deposits in Massachusetts.”<sup>61</sup>

State attempts to remedy ERISA's regulatory silence on employee welfare benefits, however, both benefited and suffered from the *Met Life* decision. In short, the Court took from the states as much as it gave. Justice Blackmun fired a parting shot in dicta—a shot that foretold a substantial loss of ground for the states:

We are aware that our decision results in a distinction between the insured and uninsured plans, leaving the former open to indirect regulation while the latter are not. By doing so we merely give life to a distinction created by Congress in the “deemer clause,” a distinction Congress is aware of and one it has chosen not to alter.<sup>62</sup>

This line of reasoning had its origins in circuit decisions dating back to 1977,<sup>63</sup> but it was not until the *Met Life* decision that the Supreme Court endorsed this

59. See, e.g., CONN. GEN. STAT. § 38-262b (Supp. 1985) (requiring coverage for alcoholism); MD. ANN. CODE, art. 48A, § 477X (Supp. 1984) (requiring that certain birth-defects be covered); OHIO REV. CODE ANN. § 3923.25 (Supp. 1984) (requiring coverage for outpatient kidney dialysis); ARIZ. REV. STAT. ANN. § 20-1402(5) (Supp. 1984-1985) (requiring coverage for reconstructive surgery for insured mastectomies).

60. See Employee Benefit Research Institute, *ERISA and Health Plans*, EBRI SPECIAL REPORT SR-31, Issue Brief No. 167, at 7 (1995) [hereinafter EBRI REPORT].

61. John C. Goodwin, *Health Insurance: States Can Help*, WALL ST. J., Dec. 17, 1991, at A20.

62. Metropolitan Life Ins. Co v. Massachusetts Travelers Ins. Co., 471 U.S. 724, 747 (1985); see also Part IV.B (discussing *FMC v. Holliday*, 498 U.S. 52 (1990), which made a holding of this *Met Life* dicta).

63. See Fox and Schaffer, *supra* note 7, at 245 (noting that the Circuit courts had implied an ERISA mandated distinction between traditionally insured plans and self-insured plans long before the issue reached the Supreme Court).

interpretation. In drawing this distinction between traditionally insured plans and "self-insured" or "self-funded"<sup>64</sup> plans, the Court prompted employers, large and small alike, to self-insure their welfare benefit plans.<sup>65</sup>

### C. Pilot Life v. Dedeaux

After the Supreme Court decided *Met Life*, there were still many state laws of general applicability<sup>66</sup> that could have potentially regulated the insurance industry.<sup>67</sup> The remaining question was whether *Met Life* would save such laws of general applicability from preemption when those laws were applied to the insurance industry.

In *Pilot Life Ins. Co. v. Dedeaux*,<sup>68</sup> the Supreme Court addressed this issue directly and held that ERISA preempted state laws of general applicability. Dedeaux, the plaintiff and respondent, brought an action against the administrator of his employer's group disability plan (Pilot Life, the petitioner).<sup>69</sup> Dedeaux relied on the *Met Life* holding—that under the savings clause, ERISA did not preempt state laws that regulated insurance.<sup>70</sup> Dedeaux argued that his claims were based on Mississippi's common law of tortious breach of contract and that Mississippi's highest court had consistently linked this common law provision with regulating the insurance industry.<sup>71</sup>

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64. See Lenhart, *supra* note 2, at 623 n.44 (pointing out that the terms "self-insured" and "self-funded" are synonymous). It should also be noted that the term "uninsured" is sometimes used as a synonym for "self-insured" or "self-funded" in reference to the fact that such plans do not purchase traditional insurance contracts from a third party provider.

65. This distinction encouraged employers to self-insure their welfare benefit plans because the self-insured insurance model allowed employers to evade state-mandated benefits. See *infra* Part IV.A.

66. One example of a law of general applicability would be a common law tort.

67. For example, a plaintiff could utilize the law of tortious breach of contract in order to bring an action against an insurer and thereby regulate the insurance industry. See *infra* note 74 and accompanying text.

68. See *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987).

69. See *id.* at 43. Dedeaux's actual employer was a company called Entex, Inc. See *id.* Entex provided its disability plan to employees by purchasing a group insurance policy from Pilot Life. See *id.* Pilot Life became the defendant in this action because Pilot Life denied Dedeaux a claim and it was Pilot Life that had the fiduciary duty to determine benefit eligibility. See *id.*

70. *Id.* at 44.

71. See *id.* at 43. It is also worth noting, as the court did in *Pilot Life*, that

The Supreme Court, however, disagreed with Dedeaux's position and held that the savings clause applied only when laws were "specifically directed toward [the insurance] industry."<sup>72</sup> The Court reasoned that the Mississippi common law provision of tortious breach of contract had not been created with the intent to regulate the insurance industry; that is, that Dedeaux's cause of action had its "roots . . . firmly planted in the general principles of Mississippi tort and contract law."<sup>73</sup>

*Pilot Life* made clear that ERISA's savings clause would not save state laws from preemption when those state laws "developed from general principles" of common law.<sup>74</sup> ERISA's savings clause, then, preserved a state's traditional authority to regulate insurance, but only with respect to state laws that were drafted specifically to regulate the insurance industry and the business of insurance.

#### D. Union Labor Life Insurance Co. v. Pireno<sup>75</sup>

The Supreme Court's decision in *Pilot Life*—to limit the scope of the savings clause to state laws that had the specific purpose of regulating insurance—is further clarified by taking note of the Court's decisions in both *Union Labor*

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Dedeaux was correct inasmuch as the savings clause of ERISA applies to "all laws, decisions, rules, regulations, or any law of any State having the effect of law, of any State." ERISA § 514(c)(1) (1974).

72. See *Pilot Life*, 481 U.S. at 50; see also *infra* Part III.D (regarding the test for whether a state law is actually regulating insurance).

73. See *Pilot Life*, 481 U.S. at 50. It was not disputed that these common law causes of action "related to" an employee benefit plan. Indeed attorneys regularly use ERISA to preempt state contract and tort claims that are brought against providers or administrators of ERISA-covered employee welfare benefit plans. See, e.g., *Toledo v. Kaiser Permanente Med. Group*, 987 F. Supp. 1174 (N.D. Cal. 1997). Plaintiffs who have their state claims preempted, however, are not without remedy. See *Pilot Life*, 481 U.S. at 55. However, these plaintiffs are left to pursue ERISA-prescribed remedies that are often less than satisfying. See ERISA § 502(g)(2) (1974). Under ERISA, a plaintiff whose health care plan administrator had negligently denied health care services to the plaintiff, thereby causing plaintiff to suffer life-threatening complications, would only be able to sue for the cost of the denied benefits—that is, the costs for the medical procedures that the plan administrator had initially denied to the plaintiff. See *id.* (prescribing and limiting a plan participant's remedies).

74. See *Pilot Life*, 481 U.S. at 51.

75. *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982).



*Life Insurance Co. v. Pireno*<sup>76</sup> and *Met Life*.<sup>77</sup> Under these rulings, the state law must regulate activities that involve the "business of insurance" in order for the law to fall under the savings clause.<sup>78</sup> The Court in *Pireno* stated that the test for whether a state law regulates the "business of insurance" is a three part test: (1) does the state law regulate in such a manner that it has the effect of transferring or spreading a policyholder's risk; (2) does the state law regulate in such a way that it affects an integral part of the policy relationship between the insurer and the insured; and (3) does the law impose requirements only on insurers.<sup>79</sup>

By applying this test from *Pireno*, the Supreme Court in *Met Life* held that the Massachusetts mandated benefits law regulated the business of insurance.<sup>80</sup> The *Met Life* court reasoned that by requiring insurers to include certain benefits in their products, Massachusetts determined that everyone who bought group health insurance should share the risk of mental health care.<sup>81</sup> Second, section 47B regulated an integral part of the policyholder-insurer relationship by "limiting the type of insurance that an insurer may sell to the policyholder."<sup>82</sup> Third, section 47B applied exclusively to insurers.<sup>83</sup>

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76. *Id.* The *Pireno* decision dealt with an insurance company seeking an antitrust exemption under the McCarran-Ferguson Act. See 458 U.S. at 126. In interpreting ERISA's savings clause, courts have borrowed freely from decisions dealing with the statutory construction of the McCarran-Ferguson Act. See e.g., *Metropolitan Life Ins. Co. v. Massachusetts Travelers Ins. Co.*, 471 U.S. 724 (1985).

77. In *Met Life*, the Supreme Court relied heavily on its decision in *Union Labor Life Insurance Co. v. Pireno*, 458 U.S. 119 (1982), in order to define what it means for a law to regulate insurance. See 471 U.S. at 741-44.

78. See *Met Life*, 471 U.S. at 744 (quoting *SEC v. National Securities, Inc.*, 393 U.S. 453, 460 (1969) ("[T]he focus [of the term 'business of insurance'] was on the relationship between the insurance company and the policyholder. Statutes aimed at protecting or regulating this relationship, directly or indirectly, are laws regulating the 'business of insurance.'"). There is an important distinction between a state law that regulates the relationship between policyholders and insurers, and a state law that regulates that relationship as a pretense in order to effect an independent policy concern. See e.g., *American Med. Sec., Inc. v. Bartlett*, 111 F.3d 358 (4th Cir. 1997).

79. See *Pireno*, 458 U.S. at 120; *Met Life*, 471 U.S. at 743.

80. See *Met Life*, 471 U.S. at 743.

81. See *id.*

82. See *id.*

83. See *id.*

Notwithstanding the success that Massachusetts had in *Met Life* with the *Pireno* test, courts have since carefully scrutinized whether a state law *actually* regulates the business of insurance. In doing so, courts have limited states' ability to affect the terms of employee welfare benefit plans through direct regulation of the insurance industry.

For example, in *Tri-State Mach., Inc. v. Nationwide Life Ins. Co.*,<sup>84</sup> the Fourth Circuit held that ERISA preempted a claim based on a West Virginia Unfair Trade Practices Act.<sup>85</sup> The *Tri-State Machine* court found that ERISA preempted the West Virginia State law in spite of the fact that the state legislature drafted this statute exclusively to regulate the insurance industry.<sup>86</sup> Specifically, the court reasoned that "this type of regulation is not unique to the business of insurance, and it does not target, at least in these provisions, the core business of insurance."<sup>87</sup> Thus, a state legislature might draft a law that explicitly regulates the insurance industry, yet ERISA could still preempt that law if the regulation was not "unique to the business of insurance . . . [and did not] target . . . the core business of insurance."<sup>88</sup>

Three years after the *Tri-State Machine*<sup>89</sup> decision, the Fourth Circuit expanded its suspicion of plaintiffs who brought state claims against ERISA-regulated employee benefit plans.<sup>90</sup> In *American Medical Sec., Inc. v. Bartlett*,<sup>91</sup> the circuit court refused to uphold an application of state laws to ERISA welfare benefit plans when the state laws merely "alleged" to regulate the insurance industry and the business of insurance, but in fact had the "intended, stated and actual effect" of reaching the relationship between

84. 33 F.3d 309, 313-14 (4th Cir. 1994).

85. See W. VA. CODE § 33-11-4 (1993). Notably, this statute appears to regulate the insurance industry and even includes a subsection that addresses unfair claim settlement practices. See *id.* § 33-11-4 (9).

86. The statute's facial concern with the insurance industry, however, failed to persuade the *Tri-State Machine* court. See 33 F.3d at 316.

87. *Id.* at 314. The court went on to define "the core business of insurance" as "contracts of protection under which risk is spread among policy holders." *Id.*

88. *Id.*

89. 33 F.3d 309.

90. See generally *American Med. Sec., Inc. v. Bartlett*, 111 F.3d 358 (4th Cir. 1997).

91. 111 F.3d 358.

employers and employees.<sup>92</sup> The issues raised by *American Medical Security* are crucial and will merit further discussion later in this Comment.<sup>93</sup>

In any event, the lesson is clear: simply because a state law purports to regulate the insurance industry does not mean that the savings clause will protect that law from ERISA preemption.

#### IV. THE RISE OF SELF-INSURANCE

##### A. Background

An employer's welfare benefit plan is "self-insured"<sup>94</sup> if the employer has taken on certain risks and liabilities connected with providing health care coverage—or any other employee welfare benefit plan for that matter. Employers that self-insure will often pay for employee benefits with money from their own assets—money sometimes kept in trust for that purpose.<sup>95</sup> By self-insuring, employers opt out of the traditional insurance model. The traditional insurance model would involve the employer contracting with third party provider of insurance—whether that be a Blue Cross/Blue Shield or an HMO. Under this traditional model, the employer then pays premiums and deductibles, and in exchange, the insurance company agrees to pay for the large majority of plan participants' medical costs in a given year.<sup>96</sup>

Recall that the Court in *Met Life* observed that which Congress had provided for in ERISA: employers who

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92. See *id.* at 363; see *infra* Part VI.D.

93. See *infra* Part VI.D.

94. "Self-insured" and "self-funded" are used interchangeably throughout this note. See *supra* note 64.

95. See generally STATE HEALTH ADVISORY COUNCIL, *supra* note 10, at 60. This public/private industry report defined self-insurance in the following way: [t]he acceptance of risk by a company or plan for medical, dental, or other covered claims incurred by plan participants. Self-insurance occurs when an organization pays health or medical claims out of its internal funds or by establishing a separate fund or "trust" . . . [c]laims under self-insurance may be [and often are] processed under an "administrative services only" contract [an "ASO"] with an insurance carrier or another claims administrator.

*Id.* at v.

96. See *id.* at v.

purchase insurance from third-party providers are subject to "indirect" state regulation of their employee benefit plans while those that self-insure are not subject to such indirect state regulation.<sup>97</sup> Under *Met Life*, employers that self-insured their health care plans could avoid complying with state-mandated benefits.

It is not entirely clear, however, that regulatory advantages were *the* reason that more and more employers began to move towards self-insured benefit plans. In fact, a 1982 report concerning self-insurance in New York rebuffed the inference that evasion of state insurance mandates motivated employers to move towards self-insurance.<sup>98</sup> The same report posited that the trend was more likely caused by considerations such as "greater concern for employee health . . . added participation in policy and planning activities . . . containing the cost of claims, improving cash flow, and earning greater returns on reserves."<sup>99</sup> In addition, a 1987 report on self-insurance in North Carolina indicated that the trend had its origins in employers' desire

to treat employees in different States equally and to avoid State premium taxes [and by employer's dissatisfaction with] the slowness of many insurers to develop and use meaningful data for cost containment . . . [as well as] by the impact of high interest rates in the early 1980s on cash management procedures.<sup>100</sup>

In switching to self-insured plans, employers were also able to realize the benefits of "better access to information and more control and flexibility in developing and administering . . . [employee welfare benefit] plan[s]."<sup>101</sup> Self-funding a plan also permitted an employer to craft a health care plan that was more neatly tailored to the needs and risks of its particular work-force.<sup>102</sup>

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97. *Metropolitan Life Ins. Co. v. Massachusetts Travelers Ins. Co.*, 471 U.S. 724, 747 (1985) (dicta).

98. See STATE HEALTH ADVISORY COUNCIL, *supra* note 10, at ix.

99. See *id.*; see also Ann Winslow, *The Financing of the U.S. Health Care Industry*, HARV. BUS. SCH. No. 196-095 (1995) (noting that reasons for self-insurance include reductions in administrative and risk costs and avoidance of premium taxes).

100. See Fox and Schaffer, *supra* note 7, at 252; see also Troy Paredes, *Stop-Loss Insurance, State Regulation, and ERISA: Defining the Scope of Federal Preemption*, 34 HARV. J. ON LEGIS. 233, 249 (1997).

101. See Paredes, *supra* note 100, at 249.

102. Mary Anne Bobinski, *Unhealthy Federalism: Barriers to Increasing*

Furthermore, self-insuring allowed an employer to avoid paying various insurance fees; fees which often represented the insurer's profit margins. Self-insuring also enabled employers to hang on to the money earmarked for the welfare benefit plan until they absolutely had to pay out on claims.<sup>103</sup> In this way, self-insured employers could earn interest on this money while waiting to pay claims. Lastly, employers that self-funded could reclaim surplus money at the end of the year.<sup>104</sup>

The position that most self-insured employers chose to self-insure regardless of state-mandated health care benefits is also substantiated by data from the early 1980s, which indicates that two out of three self-insured employers in New York provided plan participants with all state-mandated benefits.<sup>105</sup>

Notwithstanding hard data to the contrary, it is disingenuous for employers to claim that the trend towards self-insurance has had little to do with avoiding state-mandated benefit laws, state anti-subrogation laws<sup>106</sup> or other state laws that similarly protect employees' rights under traditionally insured benefit plans.<sup>107</sup> The 1982 report concerning New York may not have detected employers' desire to evade state mandates because it has only been since the mid-1980s that state health insurance reforms and benefit mandates have become more "frequent and aggressive."<sup>108</sup> In 1998, one commentator noted that "[s]ince 1975 U.S. benefits have grown from 30 percent of payroll to 41.9 percent of payroll today. Nearly half of the increase is due to the expansion of mandated benefits."<sup>109</sup>

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*Health Care Access for the Uninsured*, 24 U.C. DAVIS L. REV. 255, 297 n.139 (1990).

103. *See id.*

104. *See id.* These advantages of self-insurance could begin to fade if employers purchase stop-loss insurance in order to protect themselves against catastrophic loss. Whatever gains the employer may have realized in self-insuring might be lost by the additional purchase of a stop-loss policy. *See generally infra* Part V.

105. *See* STATE HEALTH ADVISORY COUNCIL, *supra* note 10, at ix.

106. *See infra* notes 110-115 (discussing the *Holliday* decision and anti-subrogation law).

107. *See* Paredes, *supra* note 100, at 249 ("an employer who self-insures can exploit ERISA's distinction between insured and self-insured plans and thereby avoid burdensome and costly state regulation").

108. *See* EBRI REPORT, *supra* note 60, at 12.

109. Renate M. Nellich, *Executive Partnerships in Reinsurance*, NATIONAL

The North Carolina report is deficient in that it documents a rationale for self-insuring that is peculiar to large, interstate corporations.<sup>110</sup> These large, interstate corporations have legitimate interests both in administering welfare benefit plans whose statutory minimums are uniform from state to state—thus making administration of employee benefits more efficient—and in seeing better returns on their capital—a good portion of which would typically go towards health insurance premiums.<sup>111</sup> Yet today's self-insurance terrain looks very different from that of the mid-1980s. Whereas self-insuring used to be a stratagem reserved for these large, interstate corporations, today "the size of the employers that are self-insuring has dropped dramatically."<sup>112</sup> Not only is the average size of the self-insuring employer dropping, but just as tellingly, the actual *number* of employers self-insuring is steadily rising.<sup>113</sup> In 1995, the Employee Benefit Research Institute stated bluntly that "the growth of self-insurance [today] is being driven much more by a desire simply not to be under that more extensive state regulation."<sup>114</sup> In addition, at least one recent court decision reflects the court's awareness that this surge in self-insurance has much to do with avoiding the burdens of state-mandated benefits.<sup>115</sup>

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UNDERWRITER LIFE & HEALTH-FINANCIAL SERVICES EDITION, Apr. 20, 1998.

110. See *supra* notes 100-01 and accompanying text.

111. See EBRI REPORT, *supra* note 60, at 12. ("in the early days it was principally large employers that were motivated by their multistate status as well as by financial considerations").

112. See *id.*

113. See Lenhart, *supra* note 2, at 616 n.1 (reporting that 67 percent of employers self-insured their medical plans in 1992, compared with only 47 percent in 1986).

114. See EBRI REPORT, *supra* note 60, at 12 (noting also that small companies' want to be free of state regulation not only in order to avoid mandated benefit laws, but also so that they can have more latitude to set deductible structures and have longer waiting periods); see also STATE HEALTH ADVISORY COUNCIL, *supra* note 10, at 50 (noting in a separate appendix report that "[i]nsurers were required by law to include in their health insurance . . . specified mandated benefits . . . [r]ecognizing that these legislative mandates only applied to licensed insurers, there was created an additional incentive for certain employers to opt for a self-insured program.").

115. See *American Med. Sec.*, 111 F.3d at 362 ("Apparently not wishing to be subject to state-mandated health benefits, insurance companies and their ERISA plan clients have entered into arrangements under which plans self-fund benefits . . .").

ERISA did more than simply leave a regulatory vacuum for employee welfare benefit plans. Judicial interpretation of ERISA coupled with congressional silence has given employers an *incentive* to self-insure and evade state-mandated benefits—thus exacerbating the effects of the regulatory vacuum.

## B. FMC v. Holliday

In *FMC v. Holliday*,<sup>116</sup> the Supreme Court rejected the argument that a fully self-insured employee welfare benefit plan is, in fact, an "insurer" and therefore subject to existing state insurance laws.<sup>117</sup> In *Holliday*, the petitioner and plaintiff, FMC Corporation, provided health care benefits to its employees through a self-funded health care plan.<sup>118</sup> Notably, FMC's health care plan was *entirely* self-funded and was administered without the benefit of an insurance policy provided by a third party.<sup>119</sup> FMC's health care plan contained a subrogation clause which required employees to reimburse the plan for medical costs if the plan had covered the medical treatment of an employee's injuries and that employee later received a damages award for those injuries.<sup>120</sup>

In *Holliday*, the employer sought a declaratory judgment regarding an employee's (Holliday) duty to reimburse the plan.<sup>121</sup> Ms. Holliday, the respondent and defendant, claimed that Pennsylvania State law<sup>122</sup> invalidated her employer's subrogation clause. The court in *Holliday* relied on both *Met Life* and ERISA's legislative

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116. 498 U.S. 52 (1990).

117. *Id.*

118. *See id.* at 54.

119. *Cf. American Med. Sec.*, 111 F.3d at 360; *Thompson v. Talquin*, 928 F.2d 649, 652-53 (4th Cir. 1991) (involving employers who purchased stop-loss insurance to cover themselves against catastrophic liability for costs incurred from their self-funded health care plans).

120. *See Holliday*, 498 U.S. at 54.

121. *See id.* at 56.

122. Pennsylvania's Motor Vehicle Financial Responsibility Law, 75 PA. CONS. STAT. § 1720 (1987). In relevant part, the law stated, "[i]n actions arising out of the maintenance or use of a motor vehicle, there shall be no right of subrogation or reimbursement from a claimant's tort recovery with respect to . . . benefits . . . paid or payable . . . under section 1719." *Id.* In this instance, section 1719 refers to benefits paid under a "group contract . . . for payment of [health care] benefits." *Id.*

history in holding that "the deemer clause . . . exempt[s] self-funded ERISA plans from state laws that 'regulate insurance' within the meaning of the savings clause."<sup>123</sup> The *Holliday* decision gave force to the *Met Life* dicta: state insurance regulations would not apply to employers who self-insured their welfare benefit plans.<sup>124</sup>

### C. *The Deemer Clause and the Federal Duty to Intervene*

Perhaps if we lived in a nation more concerned with full access to health care, the deemer clause would not have its present effect and ERISA would allow for state regulation of *all* forms of insurance—whether traditionally insured through a third party or self-insured. In such a world, the *Met Life* decision would have been nothing but a shot in the arm for states and their efforts to secure access to adequate health care.<sup>125</sup> However, we do not live in such a nation and this Comment does not propose that Congress will imminently modify or, even less likely, eliminate the deemer clause from ERISA.<sup>126</sup> Indeed, such a theory would run contrary to what some have identified as ERISA's crowning achievement—uniform federal regulation of employee benefits.<sup>127</sup>

As noted earlier, Congress has both simultaneously acknowledged the need for regulatory control over the

123. *Id.*

124. "[A]n employee benefit plan is not to be considered as an insurance company, bank, trust company or investment company . . . for purposes of any State law that regulates insurance companies [or] insurance contracts . . . ." *Holliday*, 498 U.S. at 63-64 (quoting H.R. Conf. Rep. No. 93-1280, p. 383 (1974)).

125. See generally Edward Alburo Morrissey, *Deem and Deemer: ERISA Preemption Under the Deemer Clause as Applied to Employer Health Care Plans with Stop-Loss Insurance*, 23 NOTRE DAME J. LEGIS. 307 (1997). The Note calls for a modification of the deemer clause to allow for state regulation of self-insured plans. *Id.* at 315. Furthermore, the author envisions that section 514(a) would preserve the federal government's exclusive power to regulate requirements of reporting, disclosure, fiduciary responsibility and general operation and maintenance of any self-insured employee welfare benefit plan—thus preserving ERISA's interest in uniformity to an extent. *Id.* This theory does not give sufficient weight to the ways in which state-mandated benefits would substantially ignore ERISA's policy in uniformity.

126. See generally *id.* (advocating an evisceration of the deemer clause so to allow the states to regulate self-insured employers as they regulated traditionally insured employers).

127. See *supra* notes 6, 18.



substantive terms of insurance contracts and effectively denied that the same need exists with respect to regulating the substantive terms of a self-insured plan.<sup>128</sup> Nevertheless, the present state of the statute and of the controlling decisional law does not and will not permit the states to regulate employers who self-insure their welfare benefit plans.

One solution is for the federal government to step into the breach created by ERISA and comprehensively regulate the substantive terms of employee welfare benefit plans.

### V. THE STOP-LOSS DILEMMA

A further wrinkle is added to this analysis, however, when one considers an inevitable corollary to the trend of smaller employers seeking the administrative, financial and regulatory advantages of self-insuring employee welfare benefit plans.<sup>129</sup> The overwhelming majority of these smaller employers, though they seek the advantages of self-insuring, are unable to assume the massive liability and tremendous risk involved in such an arrangement.<sup>130</sup> In fact, the vast majority of *all* employers that self-insure do *not* assume all of the risks and liability. Rather, they purchase stop-loss insurance to protect themselves against catastrophic loss in the event that claims far exceed their projections.<sup>131</sup>

Stop-loss insurance is a relatively new player in the area of health care insurance;<sup>132</sup> its emerging role is owed

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128. See STATE HEALTH ADVISORY COUNCIL, *supra* note 10, at 55.

129. Again, a business strategy formerly associated only with large corporations that possessed broad bases of capital.

130. See *Safeco Life Ins. Co. v. Musser*, 65 F.3d 647 (7th Cir. 1995). The court noted that "ninety-six percent of all employers with less than 1,000 employees that sponsor self-funded plans ERISA plans purchase some form of stop-loss coverage." *Id.* at 649.

131. See *id.* at 649; Lenhart, *supra* note 2, at 616 n.1 ("[s]eventy-three percent of self funded plans used stop-loss coverage [in 1992]"); see also Morrissey, *supra* note 125, at 310 (stating that the purchase of stop-loss insurance results often in the plan fitting under the category of "partially funded plan"); see generally EBRI REPORT, *supra* note 60, at 10 ("Stop-loss is something where you don't normally expect to have a claim against the coverage. Just like fire insurance on your house, you don't expect to have a claim.").

132. See generally Lawrence Allen Vranka, Jr., *Defining the Contours of ERISA Preemption of State Insurance Regulation: Making Employee Benefit Plan Regulation an Exclusively Federal Concern*, 42 VAND. L. REV. 607, 636

largely to the increasing numbers and diversity of employers seeking to self-insure. Stop-loss coverage, in the context of employee health care plans, means that the employer is self-insured but then purchases a policy that will "stop the bleeding" at a certain point. The stop-loss policy generally insures either the employer itself or the plan, and is "triggered" if the employer's payments on the plan reach a certain point in a given year.<sup>133</sup>

Stop-loss policies discussed in this Comment come in one of two forms: aggregate basis and individual/family basis. In the aggregate model, the stop-loss policy will pay out when the plan's total claims exceed projected claims by a predetermined percentage.<sup>134</sup> In the individual/family model, the same framework applies, except that the stop-loss policy is triggered when any single participant<sup>135</sup> makes claims above a certain amount (for example, \$25,000 in a given year). The point at which the stop-loss policy is triggered is called the "attachment point."<sup>136</sup>

The Supreme Court has not had an opportunity to rule on what effect the purchase of a stop-loss policy has on an employer's self-insured status. However, the growing consensus among circuit courts is that a self-insured employer's health plan does not become a traditionally insured plan nor does the employer actually purchase health care insurance when the employer purchases a stop-loss policy in order to protect itself or the plan against catastrophic loss.<sup>137</sup>

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(1989) (observing that stop-loss had been associated with insuring against losses from fire, epidemic or other "catastrophes").

133. See STATE HEALTH ADVISORY COUNCIL, *supra* note 10, at v.

134. That is, the employer and the insurer would possibly agree that the probable amount of total claims will be \$50,000 in 1998. As a result, the stop-loss policy would likely cover any amount above \$57,500 because this figure would represent 115 percent of aggregate projected claims for the year.

135. "Single" here includes a family unit.

136. See STATE HEALTH ADVISORY COUNCIL, *supra* note 10, at v.

137. See *American Med. Sec. v. Bartlett*, 111 F.3d 358 (4th Cir. 1996); *Tri-State Mach., 33 F.3d 309* (4th Cir. 1994); *Lincoln Mut. Cas. Co. v. Lectron Prod., Inc., Employee Health Benefit Plan*, 970 F.2d 206 (6th Cir. 1992); *Brown v. Granatelli*, 897 F.2d 1351 (5th Cir. 1990); *United Food & Commercial Workers & Employers Ariz. Health & Welfare Trust v. Pacyga*, 801 F.2d 1157 (9th Cir. 1986); *Thompson v. Talquin Bldg. Prod. Co.*, 928 F.2d 649 (4th Cir. 1991) (holding that employers that self-insure do not become "insured" plans through the purchase of stop-loss policies, thus application of relevant state insurance regulations is preempted). *But see Michigan United Food and Commercial Workers Unions v. Baerwaldt*, 767 F.2d 308 (6th Cir. 1984);

VI. CIRCUIT COURTS ON STOP-LOSS INSURANCE & ERISA  
PREEMPTIONA. *Circuit Split and the Prevailing Majority Opinion*

Certain circuit courts have held that an employer's welfare benefit plan remains self-insured despite the fact that the employer has bought a parallel stop-loss policy.<sup>138</sup> These decisions represent the majority opinion, as well as the more logical and persuasive school of thought. Admittedly, there are compelling arguments to support the position that an employer in fact has a traditionally insured plan when it purchases a stop-loss policy from an insurance company and also purchases administrative services from that same insurance company.<sup>139</sup> Nevertheless, a Supreme Court review of this tangled question will more than likely see the Court follow the growing majority of opinions among the circuits, and hold that an employer's welfare benefit plan is self-insured and therefore exempted from state insurance regulations<sup>140</sup>—whether the plan is

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Northern Group Services, Inc. v. Auto Owners Ins. Co., 833 F.2d 85 (6th Cir. 1987) (holding that self-insured employer who purchases stop-loss policy becomes an "insured" plan and thus is subject to state insurance regulations).

138. See *supra* note 137.

139. See Vranka, Jr., *supra* note 132, at 636 (alluding to the illogic that an employer is actually self-insured when an insurance company has both issued the employer a stop-loss policy and fully administers claims adjustments—noting that perhaps the insurer should properly be seen as the underwriter of the employer's risk and the administrator of its claims—thus its "insurer"); *Northern Group Services*, 833 F.2d at 91 (reasoning that employer's stop-loss insurance was "purchased to 'provide benefits for plans subject to ERISA' . . . [t]hat the Plan pays a deductible [i.e. claims before the attachment point] does not alter the fact that benefits payable above specified levels . . . are nonetheless insured") (quoting *Metropolitan Life Ins. Co. v. Massachusetts Travelers Ins. Co.*, 471 U.S. 724, 738 n.15 (1985)); cf. *Granatelli* 897 F.2d at 1357 (dissent) (reasoning that the employer's stop-loss policy is analogous to a group health care policy even though the policy was directly liable to the employer, not the plan's participants).

140. A recent Advisory Opinion from The U.S. Department of Labor defined certain limits of the relationship between an employer's stop-loss policy and an employee welfare benefit plan. See Op. PWBA Off. of Reg. and Interpretations No. 92-02A (Jan. 17, 1992). In that case, the employer had purchased the stop-loss policy in order to address its liability for the plan's obligations. See *id.* The Advisory Opinion stated that an employer's stop-loss policy is not an asset of the welfare benefit plan—even when the employer purchased the policy in order to address its liability under the plan. See *id.*

completely self-funded<sup>141</sup> or only "partially funded."<sup>142</sup>

## B. United Food & Commercial Workers v. Pacyga<sup>143</sup>

The Ninth Circuit has held that an employer's welfare benefit plan is *still* self-insured despite the existence of a stop-loss policy because stop-loss policies generally cover the employer or the plan—not the plan's participants themselves. The Ninth Circuit's *Pacyga* decision represents the leading decision on this issue.<sup>144</sup>

The *Pacyga* decision involved a plan administrator's action for declaratory judgment against a participant (Renee Ann Pacyga, defendant and respondent) in the employee health care plan.<sup>145</sup> Ms. Pacyga had been injured in an automobile accident and had subsequently filed a claim for benefits with her employer's health care plan.<sup>146</sup> Before the plan's trustees would release these benefits to her, however, they asked that Ms. Pacyga formally agree to reimburse the plan if she ever collected damages from the person responsible for her injuries.<sup>147</sup> Although she did so under protest, Ms. Pacyga consented to this arrangement.<sup>148</sup>

The employee welfare benefit plan in *Pacyga* was distinct from the plan that the Supreme Court would analyze four years later in the *Holliday* decision.<sup>149</sup> That is, the employer in *Pacyga* purchased a stop-loss policy to limit its liability under the plan.<sup>150</sup> The court in *Pacyga* found it irrelevant that the employer had purchased a stop-loss policy in order to limit its liability:

141. See, e.g., *FMC v. Holliday*, 498 U.S. 52, 54 (1990).

142. See, e.g., *American Med. Sec.*, 111 F.3d at 360.

143. 801 F.2d at 1158 (1988).

144. See *Morrissey*, *supra* note 125, at 311 (beginning its analysis of this issue with discussion of *Pacyga* decision).

145. 801 F.2d at 1157.

146. *Id.* at 1158.

147. *Id.* at 1159. In its statement of the facts, the court notes that it was evident early on that "a third party was at fault" in the accident. *Id.*

148. *Id.*

149. See *FMC Corporation v. Holliday*, 498 U.S. 52 (1990).

150. *Pacyga*, 801 F.2d at 1159. The court indicated that the plan was "entirely self-funded," but went on to note that the plan was "insured against aggregate catastrophic losses by a 'stop-loss' policy . . ." *Id.* The terms "self-funded" and "self-insured" are used interchangeably. See *supra* notes 64, 94. Four years after the *Pacyga* decision, in *Holliday*, the Supreme Court did note that the employer in that action had not purchased a stop-loss policy in relation to its liability under a self-funded plan. 498 U.S. at 54.

We held that a self-insured ERISA plan, which carried "stop-loss" insurance, nevertheless was not an insurance company, nor did it issue insurance contracts within the meaning of *Metropolitan Life Ins. Co. v. Massachusetts*. The type of stop-loss insurance carried by the Plan herein cannot be termed health insurance, nor can it be said that the Plan is providing an insurance contract to its participants.<sup>151</sup>

In its analysis, the *Pacyga* court concluded that the employer's stop-loss policy did not make the employer an insurer of the participants.<sup>152</sup> Subsequent case law has expanded that reasoning by also finding that stop-loss policies do not "transform" an otherwise self-insured plan into a plan that is "insured" by a third party provider.<sup>153</sup>

*Pacyga* has laid the foundation for analyzing the role of stop-loss insurance in the context of an employee welfare benefit plan's self-insured status. Specifically, the *Pacyga* court reasoned that the stop-loss policy did not alter the plan's self-insured status because "[t]he stop-loss coverage provides for payment to the Plan . . . [it] does not pay benefits directly to the participants . . . ."<sup>154</sup> In so reasoning, the *Pacyga* court identified the critical issue surrounding this dilemma: either the employer or the plan are the parties liable to the plan participants, regardless of whether the employer has purchased a stop-loss policy. The stop-loss policy does not obligate the third-party insurance company to provide direct payments or services to the plan's participants.<sup>155</sup> As a result, such stop-loss policies cannot be considered health care insurance policies.

### C. Thompson v. Talquin

In *Talquin*, the Fourth Circuit elaborated on *Pacyga* and employed a highly formal understanding of liability in order to draw a line between a traditionally insured and a self-insured plan. In *Talquin*, the plaintiffs (the Thompsons) brought an action seeking a declaratory judgment

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151. *Pacyga*, 801 F.2d at 1161.

152. *Id.* at 1161-62.

153. *See, e.g., G.R. Herberger's, Inc. v. Erickson*, 17 F. Supp.2d 932 (D. Minn. 1998).

154. *Pacyga*, 801 F.2d at 1161.

155. *Id.* at 1162.

against an employer's (Talquin) health care plan.<sup>156</sup> The plaintiffs, both the injured boy and his mother, argued that under Virginia State law the employer's health care plan was required to provide coverage for injuries sustained in connection with an automobile accident.<sup>157</sup> The employer's health care plan, however, was self-insured.<sup>158</sup> The plan's terms provided that beneficiaries of the plan were not covered for injuries suffered in connection with an automobile accident.<sup>159</sup>

In light of the Supreme Court's holding in *Holliday*<sup>160</sup>—with respect to the effect of state insurance regulations on self-insured welfare benefit plans—the plaintiffs proffered several arguments in an effort to avoid ERISA preemption of the pertinent Virginia mandated benefits law.<sup>161</sup> In relevant part, the Thompsons argued that the employer had ceased to operate a self-insured health care plan once it had purchased a stop-loss policy in connection with its liability for the health care plan's costs. The *Talquin* court responded unequivocally to this argument, and added clarity to the *Pacyga* holding:

[S]top-loss insurance does not convert Talquin's self-funded employee benefit plan into an insured plan. Even with the stop-loss coverage, Talquin's Plan is directly liable to Talquin's employees for any amount of benefits owed to them under the Plan's provisions. The purpose of the stop-loss insurance is to protect Talquin from catastrophic losses, it is not accident and health insurance for employees. Instead of covering employees directly, the stop-loss insurance covers the Plan itself. Thus, for the purposes of ERISA,<sup>162</sup> the Plan remains self-funded even with the stop-loss insurance.

This ruling from *Talquin* made explicit that which had

156. *Talquin v. Thompson*, 928 F.2d 649 (4th Cir. 1991).

157. See *supra* text accompanying note 9.

158. *Talquin*, 928 F.2d at 651.

159. *Id.*

160. 498 U.S. 52 (1990).

161. Although not relevant for the purposes of this analysis, the Thompsons did also argue that the "deemer clause" only applies to how Talquin creates and administers the Plan, and therefore the subject matter of the Plan remains subject to state law regulation." *Talquin*, 928 F.2d at 652. The court summarily dismissed this argument and relied on the Supreme Court's holding in *FMC v. Holliday* in order to hold that "so long as the Plan can be categorized as self-funded, state law cannot regulate it." *Id.*

162. *Id.* at 653.

been implied in the *Pacyga* decision: so long as stop-loss insurance is payable to the employer or the plan, the plan's status as self-funded will not be affected by the stop-loss insurance. The *Talquin* holding gave life to a formal distinction that continues to vex commentators.<sup>163</sup>

It can be argued that the formal distinction employed in *Talquin* ignores the nature and the function of the stop-loss policy. That is to say, employers often purchase a stop-loss policy in order to protect themselves against unforeseen liabilities under their health care plans. Under either the stop-loss policy or a traditional group health care policy, a payout by the insurance carrier is "triggered" by the very same events: the medical costs of the plan's participants reaching a certain level within a certain period of time.<sup>164</sup>

Intuition and logic aside, *Talquin* was in fact just the beginning of a series of similarly formal decisions.<sup>165</sup> Taken together, these cases establish that there is no analytical

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163. See Morrissey, *supra* note 125; Paredes, *supra* note 100.

164. See Paredes, *supra* note 100, at 283.

165. Federal courts almost invariably utilize a formal analysis when dealing with ERISA matters. See generally Peter D. Jacobson & Scott D. Pomfret, *Form, Function, and Managed Care Torts: Achieving Fairness and Equity in ERISA Jurisprudence*, 35 HOUS. L. REV. 985, 990-92, 1001-22 (1998) (detailing the history of formal analysis in ERISA case law and calling for a change in this approach). In fact, courts have extended formal analysis of ERISA matters well beyond issues of ERISA preemption. For example, in *Hicks v. Fleming Companies*, 961 F.2d 537 (5th Cir. 1992), a laborer had received a brochure that stated that he was covered by the employer's disability policy. However, according to ERISA, a welfare benefit plan must be administered pursuant only to the formal plan documents—as those documents are enumerated in ERISA, § 404(a)(1)(D). Under ERISA, employers must develop documents called summary plan descriptions (SPD's) as well as written plan documents. ERISA, §§ 102(a)(1); 402(a)(1); 404(a)(1)(D). Section 404(a)(1)(D) states that ERISA benefit plans will be administered pursuant to the plan's formal documents. In *Hicks*, the court held that the employee who had received the erroneous brochure was not entitled to the promised disability insurance, because the plan's formal documents, the SPD and the written plan document, did not entitle that employee to the disability insurance benefits. 961 F.2d at 542-43. In spite of the fact that the brochure had given the employee unequivocal information to the contrary, the court found that the brochure was not a formal plan document and that as a result the brochure had no effect on the plan's obligations to the employee. *Id.* For a discussion of why courts should look to use a less formal analysis when addressing ERISA issues see Peter D. Jacobson & Scott D. Pomfret, *Form, Function, and Managed Care Torts: Achieving Fairness and Equity in ERISA Jurisprudence*, 35 HOUS. L. REV. 985 (1998) (noting that while "formalism is the guiding light" in ERISA jurisprudence) . . . [f]unctional analysis has . . . advantages over the formal analysis courts currently employ").

link between the fact that an employer's plan pays benefits to its participants and the fact that the stop-loss insurance carrier indemnifies the employer or the plan against catastrophic loss. Under this formal understanding, these two considerations do *not* inform the determination of whether a plan is self-insured. The employer essentially acts as a "partition" between the plan's participants and the stop-loss insurer's liability.<sup>166</sup> If the stop-loss policy named the plan's participants themselves as the policy's beneficiaries (rather than the employer or the plan), then courts would presumably recognize that such a plan was in fact traditionally insured. In such a case, the reviewing court would be forced to recognize this distinction and acknowledge that such welfare benefit plan was insured.<sup>167</sup>

#### D. American Medical Security, Inc. v. Bartlett<sup>168</sup>

Recently the Fourth Circuit has delivered a crushing and, in all likelihood, fatal blow against states and their hopes of circumventing ERISA's exclusive regulation of employee benefit plans. In *American Medical Security*, Maryland attempted to address a growing problem: employers evading state-mandated health insurance benefits by self-insuring their health care plans and then purchasing a stop-loss policy in order to guard against losses greater than what the employer was willing to absorb.<sup>169</sup> Writing for the Fourth Circuit, Judge Niemeyer related the problem that the Maryland Insurance Commissioner perceived:

Thus, by absorbing a minimal amount of initial risk and insuring the remainder through stop-loss insurance, [employers and their] plans are able to provide health benefits of a kind or at a level

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166. See *American Med. Sec.*, 111 F.3d at 364 ("Participants and beneficiaries in self-funded plans may not have the security of the insurance company's assets because stop-loss insurance insures the [employer's] plan and not the participants.").

167. See e.g., *Bone v. Association of Mgmt. Servs., Inc.*, 632 F. Supp. 493 (S.D. Miss. 1985). The majority of these cases have involved stop-loss policies that have no reference whatsoever to the plan's participants. See *supra* note 137 (regarding the "majority opinion" decisions).

168. 111 F.3d 358 (4th Cir. 1997).

169. *Id.* at 361-62.



different from what State law requires of health insurance.<sup>170</sup>

The situation prompted the Maryland Insurance Commissioner to promulgate regulations which "require[d] [self-insured] plans to absorb the risk of at least the first \$10,000 of benefits paid to each beneficiary."<sup>171</sup> If a self-insured employer then failed to take on the minimum amount of uncovered risk, the law would deem that employer's stop-loss policy to be health insurance.<sup>172</sup> Thus, such a stop-loss policy would be forced to carry Maryland's various mandated benefits.<sup>173</sup>

The Maryland Commissioner's regulation was based on a basic understanding of *what insurance is*—the transfer of risk from one party to another and the bearing of that risk by one of the parties—that is, the carrier.<sup>174</sup> This simple truth seemed to imply that an employer who claimed to be self-insured, but who had had not taken on a reasonable amount of risk, was in fact *not* self-insured.<sup>175</sup>

The *American Medical Security* court, however, found the rationale of the Maryland regulation to be unpersuasive. The court first found that the Maryland regulations certainly "related to" an ERISA plan, and then proceeded to determine whether the savings clause could

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170. *Id.* at 362.

171. *Id.*

172. *Id.*

173. *Id.*; see also American Law Institute & American Bar Association, *What's New in Employee Benefits: A Summary of Current Cases and Other Developments*, AMERICAN LAW INSTITUTE - AMERICAN BAR ASSOCIATION CONTINUING LEGAL EDUCATION ALI-ABA COURSE OF STUDY MATERIALS: PENSION, PROFIT-SHARING, WELFARE, AND OTHER COMPENSATION PLANS, Mar. 25, 1998, at 166.

174. See 1 COUCH ON INSURANCE §17:7 (3d ed. 1997) ("In order to have a contract of insurance there must be a risk which is specified or capable of identification, because coverage of a risk is the very essence of insurance."); see also *Jordan v. Group Health Ass'n*, 107 F.2d 239 (1939) (holding that the incidental involvement of an element of risk in a contract does not render the contract one of insurance).

175. See *American Med. Sec.*, 111 F.3d at 362. The court quotes the commissioner to the effect that:

[a]t very low attachment points, however, a 'stop-loss' policy is merely a substitution for health insurance . . . The goal is obvious: As policies become available with attachment points lower than many deductibles, it became an increasingly attractive option to 'self-insure' a health plan, but to continue to shift the majority of the risk to the insurance carrier by purchasing 'stop loss' coverage.

*Id.*

prevent the regulations from being preempted.

In its savings clause analysis, the court relied on the "business of insurance" framework set forth in *Pireno*<sup>176</sup> and *Met Life*.<sup>177</sup> Specifically, the *American Medical Security* court observed that in order for the Maryland regulation to fall under the savings clause, the regulation must affect the issue of spreading risk for a policyholder; affect an "integral part" of the insured and insurer's relationship and be specifically directed at the insurance industry.<sup>178</sup>

In determining whether the Maryland regulations actually "regulated insurance" within the meaning of ERISA's savings clause, the *American Medical Security* court analyzed the regulations' purpose and effect.<sup>179</sup> Maryland's minimum attachment points for stop-loss policies<sup>180</sup> did force self-insured employers to take on more risk, and as a result the regulation satisfied the first element of the *Pireno* test.<sup>181</sup> Similarly, the regulation of minimum attachment points addressed "integral" aspects of the insured and insurer's relationship and limited its scope to entities within the insurance industry.<sup>182</sup> As a result, the Maryland regulation arguably qualified as a law "regulating insurance" under ERISA's savings clause.

The court, however, took a cue from the Supreme Court's *Holliday* decision, and refused to accommodate this "backdoor attempt[ ] . . . to regulate core ERISA concerns in the guise of insurance regulation."<sup>183</sup> The *American Medical*

176. 458 U.S. 119, 122 (1982).

177. 471 U.S. 724, 743 (1985).

178. *American Med. Sec.*, 111 F.3d at 363.

179. It is ironic that the court employed such a functional analysis here, given the prominent role that formal analysis has played in this particular realm of ERISA preemption. Many courts have recently relied on a very formal analysis when evaluating employers that self-insure their benefit plans but also purchase stop-loss insurance. See *supra* note 164 and accompanying text. Courts have found that such employers are, in fact, self-insured because regardless of how inter-related the stop-loss policy and the health care plan may seem to be—the two issues remain discrete and independent concerns. See *supra* note 137 (regarding the "majority opinion" decisions).

180. That is, stop-loss policies purchased in connection with potential liability for health care costs under self-insured arrangements.

181. *American Med. Sec.*, 111 F.3d at 363 ("Higher attachment points burden plans with more risk while lower attachment points increase insurance company risk.").

182. *Id.* at 363-64. That is, the extent to which one of those two parties is legally obligated to retain a level of risk in the reinsurance relationship.

183. *FMC v. Holliday*, 498 U.S. 52, 56 (1990) (citations omitted). The court

*Security* court looked past the formal scope of Maryland's regulation and concluded that the regulation was actually an attempt to "reach the plan [and] participant relationship, a relationship which is outside the insurance industry."<sup>184</sup> In so holding, the court chose to ignore the literal import of the regulations' language, and instead reasoned that the regulations had the purpose and effect of preventing employers from evading state-mandated health care benefits. As such, the regulations did more than just regulate "integral" aspects of the insured and insurer's relationship—they impermissibly regulated the relationship between the plan and its participants.

In addition, the regulations also affected employers that sponsored the self-insured plans—entities outside of the insurance industry.<sup>185</sup> In light of this analysis under *Pireno* and *Met Life*, the Maryland regulations failed to qualify for the protection of ERISA's savings clause.

## VII. THE FUTURE OF ERISA PREEMPTION

### A. *Can States Recoup Power By Regulating Stop-Loss Policies?*

The Supreme Court's decision in *Met Life* was a decision that faithfully mirrored the "give and take" schizophrenia of ERISA's preemption policies.<sup>186</sup> *Met Life* "gave" to the states by confirming their ability to manage ERISA plans through regulations of the substantive terms of insurance contracts.<sup>187</sup> However, the same decision "took" from the states the critical ability to regulate the substantive terms of employers that self-insured their welfare benefit plans.<sup>188</sup> Justice Blackmun was aware of this

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notes in dicta that it has long recognized and prohibited "state insurance regulations that are pretexts for impinging upon core ERISA concerns." *Id.* at 63.

184. *American Med. Sec.*, 111 F.3d at 363.

185. *Id.* at 364.

186. Cf. ERISA § 514(b)(2)(A), (b)(2)(B) (containing the savings and deemer clauses, the former giving back to states the power to regulate insurance and the latter taking a great deal of that power away and in so doing arguably creating a dubious policy incentive for employers to self-insure in order to avoid state insurance regulations).

187. See *Met Life*, 471 U.S. at 746; see also *supra* Part III.B.

188. See *Met Life*, 471 U.S. at 745.

distinction, but he assigned to Congress whatever responsibility there might be for such an outcome.<sup>189</sup>

The *American Medical Security* decision has all but foreclosed speculation that the states themselves might remedy the regulatory vacuum that surrounds employee welfare benefit plans. There has been some noise that the states still have the power to salvage the power that *Met Life* gave to them.<sup>190</sup> The gist of this argument is that because the states cannot regulate the substantive terms of self-insured plans directly, the states should begin to regulate the substantive terms of stop-loss policies that self-insured employers are purchasing.<sup>191</sup>

This argument—that the states have it within their power to reach the substantive terms of stop-loss policies—although appealing on many levels, is not a sound one.<sup>192</sup> One proffered justification for allowing states to regulate stop-loss policies has been based on the Supreme Court's decision in *New York State Conference of Blue Cross and Blue Shield Plans v. Travelers Insurance Company*.<sup>193</sup> The *Travelers* court held that states may regulate in areas of traditional state authority,<sup>194</sup> and in so doing may *indirectly* affect the costs of administering a self-funded plan.<sup>195</sup> However, the argument that *Travelers* also implies that

189. 471 U.S. at 747 ("By so doing we merely give life to a distinction created by Congress in the 'deemer clause,' a distinction Congress is aware of and one it has chosen not to alter."). Indeed, it is the ultimate contention of this Comment that as the statutory and decisional law now stands, only Congress has it in its power to remedy the present problem. See *infra* Conclusion.

190. That is, the power to indirectly regulate the ERISA welfare benefit plan through substantive regulation of self-insured employer's stop-loss policies. See *Brown v. Granatelli*, 897 F.2d 1351, 1353 (5th Cir. 1990) (observing in dicta that it is not beyond the realm of possibility that state insurance regulations could be crafted and applied to self-insured employer's stop-loss policies); see generally Paredes, *supra* note 100.

191. See Paredes, *supra* note 100, at 259-62.

192. It should be noted that the court in *Met Life* upheld Massachusetts' regulation in large part because the court found that regulation of the substantive terms of insurance contracts was an area of traditional state authority. *Metropolitan Life Ins. Co. v. Massachusetts Travelers Ins. Co.*, 471 U.S. 724, 740-41 (1985).

193. 514 U.S. 645 (1995).

194. *Id.* In the *Travelers* decision, the state regulation involved mandatory surcharges for hospital stays when the insurers were "commercial insurers . . . self-insured funds . . . certain workers' compensation, volunteer firefighters' benefit, ambulance workers' benefit, and no fault motor-vehicle insurance funds . . ." 514 U.S. at 650.

195. See Paredes, *supra* note 100, at 245; see *Travelers*, 514 U.S. at 656-57.

states may regulate the substantive terms of self-insured welfare benefit plans' stop-loss insurance must fail. Indeed, there are marked differences between New York State imposing *generally applicable* hospital surcharges in the *Travelers* case,<sup>196</sup> and another state passing a law requiring that only *particular* stop-loss policies provide *certain* mandated health care benefits.

Although this logic did allow Massachusetts to prevail in *Met Life*,<sup>197</sup> the analogy breaks down here when the facts are expanded to include state mandates that would require only *certain* reinsurance policies (that is, stop-loss policies purchased in connection with health care plans) to carry *certain* terms of coverage. State regulations that require *all* commercially sold group health care policies to include certain terms of coverage are, on their face, *general* regulations of the insurance industry—laws passed with the purpose and effect of regulating the insurance industry. On the other hand, the analysis differs for a law that requires only *particular* stop-loss policies to provide specific terms of coverage *in the event that* an employer has purchased the stop-loss policy as protection against catastrophic liability from the employer's self-insured health care plan. In other words, the purpose and effect of such a law would be "[to] use stop-loss insurance policies as a vehicle to impose the requirements of [state] health insurance law on self-funded ERISA plans."<sup>198</sup>

Furthermore, there is language in the *Travelers* decision that would preclude a state's attempt to regulate employee welfare benefit plans through the regulation of those plans' stop-loss insurance policies. The *Travelers* court found it significant that New York State's hospital surcharges did not force ERISA plan administrators to buy their hospital coverage from a Blue Shield plan.<sup>199</sup> However, any state requirement that self-insured employers carry certain health care coverage on their stop-loss insurance would run afoul of the Supreme Court's warning in *Travelers*, which stated:

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196. See *Travelers*, 514 U.S. at 661-62.

197. In *Met Life*, the Supreme Court upheld Massachusetts's mandates that required certain terms of coverage for *all* commercially sold group health insurance policies. 471 U.S. 724.

198. *American Med. Sec.*, 111 F.3d at 364.

199. *Travelers*, 514 U.S. at 664-65.

We acknowledge that a state law might produce such acute, albeit indirect effects, by intent or otherwise, as to *force an ERISA plan to adopt a certain scheme of substantive coverage . . .* and that such a state law might indeed be preempted under § 514.<sup>200</sup>

Clearly, a state law that required self-insured employers to provide certain minimum state-mandated health care benefits would also dictate the extent of coverage under an ERISA health care plan. Such a law would run afoul of this admonition from *Travelers*.<sup>201</sup>

Any attempt to justify such a state law on other grounds would be transparent and, in all likelihood, dismissed as a ruse—a ruse designed to mask a state's "back-door"<sup>202</sup> attempt at regulating an ERISA plan. A state's attempt to regulate employee welfare benefit plans by imposing this sort of conditional regulation on stop-loss insurance would have "a much more direct impact on employee benefit plans because [such regulations] would appl[y] specifically to stop-loss insurance that is sold only to benefit plans."<sup>203</sup>

In the end, state attempts to regulate the substantive terms of stop-loss insurance may ultimately fail because state regulators will not be able to deny the basic differences that exist between group health insurance and stop-loss insurance.

Unlike traditional group-health insurance, stop-loss insurance is akin to reinsurance in that it does not provide coverage directly to plan members or beneficiaries. Rather, most stop-loss policies . . . provide coverage to the plan itself if the total amount of claims paid by the plan exceeds the amount of anticipated claims by a specified sum.<sup>204</sup>

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200. *Id.* at 668 (emphasis added).

201. *Cf. id.* at 656. To require an employee welfare benefit plan to provide certain coverage when that plan is self-insured would not only have the effect of forcing that plan to carry state-mandated coverage, but it would also effectively deem that plan to be an insurer by regulating that plan as the state might regulate an insurance provider. See ERISA §514(b)(2)(B). Such a state law would violate the rule set forth in *Travelers* inasmuch as the law would leave self-insured plans that purchase stop-loss policies with no choice but to comply with state mandates. See *Travelers*, 514 U.S. at 667-68.

202. See *Holliday*, 498 U.S. at 56 (citations omitted).

203. *Analysis of Current Regulatory, Legislative and Judicial Developments, TAX MGMT. COMPENSATION PLAN. J., RECENT DEVELOPMENTS*, 115 (1996).

204. *Travelers Ins. Co. v. Cuomo*, 14 F.3d 708, 723 (2d Cir. 1993), *rev'd on*

Other scholars have argued that ERISA's legislative history would allow a court to find that the scope of ERISA preemption should be loosened, so that the interests of plan participants might be privileged over the interests in uniform federal regulation.<sup>205</sup> Concededly, ERISA produced an epic amount of legislative history.<sup>206</sup> The prospect of mucking about in ERISA's legislative history does not hold out the promise of unearthing a clear congressional intent to champion the interests of plan participants over the goal of uniform federal regulation.<sup>207</sup> On the contrary, exclusive and uniform federal regulation of employee benefit law was seen as "the crowning achievement of this legislation."<sup>208</sup> Furthermore, the statute's language itself provides evidence that Congress anticipated the preemption provision's potential for creating undesirable and sometimes inequitable consequences.<sup>209</sup> In light of this apparent awareness, it would appear that Congress was prepared to unleash preemption for good and for ill; so that ERISA could effect exclusive federal regulation of employee

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*other grounds*, 514 U.S. 645 (1995).

205. See, e.g., Paredes, *supra* note 100.

206. See generally David Gregory, *The Scope of ERISA Preemption of State Law: A Study of Effective Federalism*, 48 U. PITT. L. REV. 427, 443-451 (1987).

207. ERISA's powerful preemption was one of the only aspects to this massive social regulation in which business interests found any redeeming value. See *supra* notes 14-18 and accompanying text. ERISA's sweeping preemption of state regulation, then, can be seen properly as a crucial concession to corporate America—a concession with which ERISA will not readily part. See *supra* notes 14-18 and accompanying text.

208. See 120 CONG. REC. 29, 197 (1974) (remarks of Rep. Dent); see also *supra* note 18 (containing Rep. Dent's remarks on this matter).

209. The deemer clause allowed employers whose group benefit plans were self-insured to avoid, *inter alia*, state regulations and various transaction costs. See *Metropolitan Life Ins. Co. v. Massachusetts Travelers Ins. Co.*, 471 U.S. 724, 741-42 (1985). Presumably, the fact that employers were self-insured would detract from business that would have otherwise gone to insurance companies. Section 514(b)(2)(B) suggests that ERISA's drafters were keenly aware of the effects that ERISA's deemer clause was to have on the insurance industry. Section 514(b)(2)(B) excludes self-funded life insurance policies from the deemer clause. One can reasonably conclude that this provision was intended to placate the insurance industry; an industry that stood to lose business if employers began to self-insure all of their group welfare benefit plans. By excluding life insurance from the deemer clause's language, Congress assured the insurance industry that ERISA would not provide employers with an incentive to self-insure their group life insurance plans. Section 514(b)(2)(B), then, preserved life insurance policies as an insurance industry staple—unaffected by the deemer clause.

benefits.

There is also an argument to be made for examining the functional relationship between stop-loss policies and the corresponding employee benefit plans.<sup>210</sup> Under this line of thinking, courts would assign less significance to the formal, discrete categories assigned to stop-loss insurance and self-insured plans.<sup>211</sup> In other words, if the stop-loss policy allows the employer to pay what are essentially deductibles under a traditional third party arrangement, then the courts should see through the ruse and find that such a plan is functionally insured. This line of thinking, while persuasive, would also probably fail. Again, in interpreting ERISA, courts have employed and continue to employ highly formal analytical frameworks.<sup>212</sup>

### B. Was American Medical Security a Mere Aberration?

Fred Nepple, chairman of the National Association of Insurance Commissioners<sup>213</sup> Kansas City-based ERISA working group, has communicated his belief that "the Fourth Circuit's ruling [in *American Medical Security*] . . . was an anomaly and other circuit courts [will] uphold" regulations such as those that were found to be preempted

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210. See generally Jacobson & Pomfret, *supra* note 165 (calling for a more functional analysis of ERISA matters); see also, e.g., Brown v. Granatelli, 897 F.2d 1351, 1358 n.5 (1990) (Brown, J. dissenting) ("That the plan pays a deductible does not alter the fact that benefits payable above specified levels, either on an individual beneficiary or in the aggregate, are nonetheless insured."); Michigan United Food and Commercial Workers Unions and Food Employers Health v. Baerwaldt, 767 F.2d 308, 313 (1985) ("the plans include an arrangement whereby the plans pay premiums to Occidental to insure that Occidental will pay all benefits in excess of the claims liability limit under the group policies. As long as the plans purchase insurance from 'an insurer offering health insurance policies in' Michigan, the policies must include the substance abuse coverage specified by Act 429.").

211. See *supra* Part VI.C (discussing formal understanding of stop-loss arrangements).

212. See *supra* notes 164, 177 and accompanying text.

213. The National Association of Insurance Commissioners ["NAIC"] is an "organization of insurance regulators from the 50 states . . . . The NAIC provides a forum for the development of uniform policy when uniformity is appropriate . . . the NAIC staff provides invaluable support to insurance commissioners." Homepage of the National Association of Insurance Commissioners, at <<http://www.naic.org/>>, (collected on August 12, 1999, on file with the Buffalo Law Review).



in *American Medical Security*.<sup>214</sup> The NAIC has assisted the states in their efforts to regulate stop-loss insurance as though it were health insurance by having its State and Federal Health Insurance Legislative Policy Task Force draft a Stop-Loss Insurance Model Act in 1992.<sup>215</sup> In 1995, the NAIC officially adopted this model act.<sup>216</sup>

Undeterred by *American Medical Security*, certain state legislatures and state insurance commissioners have followed the NAIC's lead. For example, Minnesota recently passed laws pushing self-insured employers to purchase stop-loss insurance with certain minimum attachment points.<sup>217</sup> The Minnesota laws require that:

A health provider cooperative shall not contract with a . . . self-insured employer plan under section 62R.17 unless the . . . self-insured employer plan maintains a policy of stop loss or excess loss insurance from an insurance company licensed to do business in this state in accordance with the following . . .<sup>218</sup>

The statute then goes on to define what "stop loss" insurance is by delineating different minimum attachment points for employers of different sizes. A self-insured employer in Minnesota with more than 750 employees "must not maintain a policy of stop loss, excess loss, or similar coverage with an attachment point less than 120 percent of the self-insured employer plan's annual expected benefit costs."<sup>219</sup> On the other hand, the law takes a different view of stop-loss insurance when self-insured employers with fewer than two hundred employees purchase stop-loss coverage that has:

(1) has a specific attachment point for claims incurred per individual that is lower than \$10,000; or (2) has an aggregate attachment point that is lower than the sum of: (i) 140 percent of the first \$50,000 of expected plan claims; (ii) 120 percent of the

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214. Dan Lonkevich, *NAIC Takes Second Look at Regulating Stop-Loss Sold to Self-Insureds*, NATIONAL UNDERWRITER PROP. & CASUALTY, Sep. 17, 1998 (available on Westlaw at 1998 WL 9516985).

215. *Model Laws, Regulations and Guidelines Accident and Health Insurance Delivery Systems Stop Loss Insurance Model Act*, NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS (1998), available in WL NAIC-MODLRG Database.

216. *See id.*

217. *See* MINN. STAT. §§ 60A.235, 62R.19 (1998).

218. *Id.* § 62R.19

219. *Id.*

next \$450,000 of expected plan claims; and (iii) 110 percent of the remaining expected plan claims.<sup>220</sup>

In addition, Pennsylvania and New Jersey have enacted laws and regulations addressing when the state will deem stop-loss insurance carriers to be health insurance carriers—thereby subjecting those carriers to state mandates for health insurance policies.<sup>221</sup>

As of the writing of this Comment, no federal district or circuit court has had the opportunity to rule on these new state regulations or on the issues that the Fourth Circuit addressed in *American Medical Security*.<sup>222</sup> However, the Supreme Court recently weighed in, albeit passively, on this debate. In June, 1998 the Supreme Court let stand the Fourth Circuit's decision in *American Medical Security* and denied Maryland's *petition for certiorari*.<sup>223</sup> In doing so, the Supreme Court may have merely intended to allow the federal circuits an opportunity to sort out this issue. However, if the Fourth Circuit's decision in *American Medical Security* had been an "anomaly," then surely the

220. *Id.* §60A235(3)

221. See 31 PA. Code § 89.472 (1998). "The individual stop-loss amount; that is, retention or attachment point per claimant shall be at least \$10,000; the aggregate stop-loss amount for the plan shall be, at a minimum, \$100,000 per calendar year." *Id.*; see also 40 PA. STAT. § 477b (1998) (providing statutory authority). New Jersey requires more from self-insured employers than Pennsylvania does:

"Stop loss" . . . means an insurance policy designed to reimburse a self-funded arrangement for catastrophic, excess or unexpected expenses wherein neither the employees nor other individuals are third party beneficiaries under the insurance policy. In order to be considered stop loss . . . for purposes of the Individual Health Insurance Reform Act, the policy shall establish a per person attachment point . . . or aggregate attachment point . . . or both, which meet the following requirements: 1. If the policy establishes a per person attachment point or retention, that specific attachment point or retention shall not be less than \$20,000 per covered person per plan year; and 2. If the policy establishes an aggregate attachment point or retention, that aggregate attachment point or retention shall not be less than 125 percent of expected claims per plan year.

N.J. ADMIN. CODE tit. 11 § 20-1.2 (1998).

222. *But see* *Associated Industries of Missouri v. Angoff*, 937 S.W.2d 277 (Mo. Ct. App., 1996) (holding that Missouri state insurance commissioner did not have requisite statutory authority to regulate certain stop-loss insurance as though it were group health insurance and declining to rule on issue of whether ERISA would preempt such state regulation).

223. *Larsen v. American Med. Sec.*, 118 S. Ct. 2340 (1998).

Supreme Court would have righted the error and cleared the way for the states to regulate stop-loss carriers that are functioning as health insurance carriers. Tellingly, the Supreme Court chose not to intervene.

Despite Maryland's defeat in *American Medical Security*, and despite the Fourth Circuit's persuasive reasoning, some states continue to regulate stop-loss insurance as though it were health insurance. In truth, this kind of stop-loss insurance is "still in the regulatory cross hairs."<sup>224</sup> Nevertheless, *American Medical Security* clearly threatens those states that persist in these kinds of regulatory efforts.

### C. Low Attachment Points—Modifying the Scope of the Deemer Clause?

Fifth Circuit Judge Patrick Higginbotham hinted at the possibility that, at some point, attachment points on a stop-loss policy would be so low as to remove an employer's plan from the realm of the self-insured.<sup>225</sup> In dicta from *Brown v. Granatelli*, Judge Higginbotham opined that if an employer's attachment point was "only the first \$500 of a beneficiaries' health claim . . . [then] labeling its coverage stop-loss . . . would not mask the reality that it is close to a simple purchase of group accident and sickness coverage."<sup>226</sup> Judge Higginbotham picked up on the very phenomenon that so incensed the Maryland Insurance Commissioner in *American Medical Security*: when standard deductibles in group insurance policies are roughly equivalent to the attachment points in stop-loss policies—employers are effectively "insured" and therefore should not escape state regulation.<sup>227</sup> The *American Medical Security* and *Travelers* decisions, however, make clear that federal courts will not permit the states to use their power to regulate insurance in order to define which benefit plans are insured and which are truly self-insured.<sup>228</sup>

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224. Self-Insurance Institute of America, Stop-Loss Insurance—Still in the Regulatory Cross Hairs, at <<http://www.siaa.org/htdocs/legislative/leg99.htm>> (collected on August 12, 1999, on file with the Buffalo Law Review).

225. See *Brown v. Granatelli*, 897 F.2d 1351 (1990).

226. *Id.* at 1355.

227. See *American Med. Sec., Inc. v. Bartlett*, 111 F.3d 358, 362 (4th Cir. 1996).

228. See *id.* at 363; *New York State Conference of Blue Cross and Blue Shield Plans v. Travelers Insurance Co.*, 514 U.S. 645 (1995).

A variation on Maryland's strategy in *American Medical Security* could eventually succeed if Congress amended ERISA itself to allow for the "minimum attachment points" regulation attempted by Maryland. Under such a plan, Congress would amend ERISA to include a clause modifying the scope of the deemer clause. A proposal for such federal reform might state that:

An employee benefit plan shall not be deemed to be an insurance company, in the business of insurance, nor an insurer . . . for the purposes of paragraph 514(b)(2)(B), if said state laws regulate an employee benefit plan that is traditionally insured through a third party commercial insurance provider. When an employer or welfare benefit plan sponsor has purchased reinsurance for a welfare benefit plan and that reinsurance carries attachment points for the employer or plan sponsor that: (a) are less than the sum of the employer or plan sponsor's number of employees multiplied by the sum of \$10,000 (if the attachment points are measured in the aggregate), or (b) average less than \$8,000 per employee.<sup>229</sup>

The upshot of such federal reform, however, would contravene traditional notions of federalism. That is, such an amendment to ERISA would involve the federal government regulating the insurance industry—an area of regulation reserved historically to the several states.<sup>230</sup>

In addition, such an amendment would have Congress going out of its way to defeat its own legislative purpose and intent in ERISA: effecting uniform regulation of employee benefits. Admittedly, the Supreme Court in *Met Life* has already signaled that the savings clause will, in part, compromise the goal of exclusive and uniform federal regulation.<sup>231</sup> Notwithstanding the concession to states' interests embodied in the savings clause, it is unlikely that Congress would exacerbate ERISA's schizophrenia by asserting exclusive federal regulation of employee benefits and then simultaneously exposing those benefit plans to disparate state regulations.<sup>232</sup> Put another way, any ERISA amendment that allows individual states to regulate benefit

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229. Under ERISA's current structure, such a provision would likely appear as section 514(b)(2)(B)(i)—and would no doubt be more artfully and carefully by a subcommittee staff.

230. See McCarran-Ferguson Act of 1945, 15 U.S.C. § 1011, et seq. (1992).

231. 471 U.S. 724; see also ERISA § 514(b)(2)(A).

232. See generally *supra* notes 6, 18 and accompanying text.

plans is unlikely because it would destroy uniform regulation of employee benefits for tens of thousands of small and mid-sized employers.<sup>233</sup>

### CONCLUSION

In essence, the states are powerless to fill the persistent regulatory gaps which ERISA created. At the time of ERISA's passage, many of its sponsors might have believed that the interests of plan participants would not require the states' protection.<sup>234</sup> Many experts and analysts were predicting that the federal government would intercede with comprehensive regulation or "perhaps even national health insurance."<sup>235</sup> Given the benefit of hindsight, the aforementioned reliance on the federal government was ill-advised.<sup>236</sup>

As politically unpopular as it may be to say, it is nevertheless true: ERISA plan participants need an active and "big" federal government to intervene on their behalf. This Comment does not suggest that the federal government should begin to dabble in the substantive regulation of insurance contracts themselves.<sup>237</sup> Instead, the federal government should acknowledge that ERISA has blocked and thwarted states' efforts to ensure that employee health plans include all reasonable and necessary terms of coverage. The combination of self-insurance and stop-loss policies has allowed employers to take on a limited amount of risk and then deny participants that which the states have determined to be the bare minimum of health care coverage.<sup>238</sup>

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233. Recall that large employers have self-insured their employee benefits for irrespective of regulatory advantages and have less need of low attachment points on stop-loss insurance because of their economies of scale. *See supra* Part IV.A.

234. *See* Fox and Schaffer, *supra* note 7, at 244-45.

235. *Id.* at 244; *see also* Kenneth R. Wing, *The Impact of Reagan-Era Politics on the Federal Medicaid Program*, 33 CATH. U.L. REV. 1, 23-24 & n. 91(1983) (providing a brief overview of President Carter's failed press for national health insurance).

236. *See supra* Part III.A (discussing President Carter's failed attempt at national health care reform and President Reagan's push towards deregulation).

237. The McCarran-Ferguson Act reserved this power to the states. *See supra* note 29 and accompanying text.

238. *See supra* notes 108-115 and accompanying text; *see also supra* Parts V,

The time has come for the federal government to fill the regulatory vacuum that it created when it passed ERISA. Filling this void can be accomplished by regulating the substantive terms of employee welfare benefit plans themselves. Although the Clinton administration failed in its attempts to champion comprehensive national health care reform,<sup>239</sup> the federal government has demonstrated that it knows how to mandate health care benefits. Unlike state mandated benefits, these federal mandates apply to traditionally insured plans and self-insured plans alike.<sup>240</sup> For example, The Newborns' and Mothers' Health Protection Act of 1996 requires, *inter alia*:

... In general: A group health plan, and a health insurance issuer offering group health insurance coverage, may not: (A) except as provided in paragraph (2): (i) restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child, following a normal vaginal delivery, to less than 48 hours, or (ii) restrict benefits for any hospital length of stay in connection with childbirth for the other or newborn child, following a cesarean section, to less than 96 hours, or (B) require that a provider obtain authorization from the plan or the issuer for prescribing any length of stay required under subparagraph (A) (without regard to paragraph (2)).<sup>241</sup>

Congress passed the Newborns' and Mothers' Health Protection Act, however, only in reaction to public outcry over highly publicized "drive-through" deliveries.<sup>242</sup> Indeed, the federal government has a history of mandating benefits in an ad hoc manner by "chipping away" from year to year.<sup>243</sup> The federal government's strategy on this front has been aptly characterized as "mandate by body part."<sup>244</sup> This

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#### VI.

239. See The President's Health Sec. Act, Title VII of H.R. 3600, S. 1757 and S. 1775 (Nov. 20, 1993).

240. See, e.g., Newborns' and Mothers' Health Protection Act of 1996, 42 U.S.C. § 300gg-4 (1997); Mental Health Parity Act of 1996, 29 U.S.C. § 1185a, 42 U.S.C. § 300gg-5 (1997).

241. 42 U.S.C. § 300gg-4 (1997).

242. See, e.g., Shelby Gilje, *Health Coverage: What Women Need To Know*, THE SEATTLE TIMES, Nov. 25, 1998, at D1.

243. See Self-Insurance Institute of America, *New ERISA Mandates Chipping Away at Self-Insured Health Plans*, at <<http://www.siaa.org/htdocs/legislative/leg99.htm>> (collected on August 12, 1999, on file with the Buffalo Law Review).

244. See *id.*

trend continued with the 105th Congress. "Provisions added at the 11th hour in the omnibus budget bill" passed by the 105th Congress will require self-insured plans to "provide certain [benefits] following a mastectomy."<sup>245</sup> On October 21, 1998, President Clinton signed this narrow provision into law.<sup>246</sup> The Women's Health and Cancer Rights Act of 1998 certainly brought about needed change for female participants in all ERISA-regulated health plans—self-insured and traditionally insured alike. However, the federal government's approach toward mandated benefits needs to be proactive and comprehensive rather than ad hoc and reaction based. Notably, Congress already mandates that the states' Medicaid programs provide recipients with a particular group of benefits.<sup>247</sup>

The present situation demands that the federal government abandon its policy of "mandate by body part" and craft a reasonable though comprehensive set of mandated benefits for self-insured health plans. The federal government must fulfill this duty to ERISA plan participants; a duty that it assumed in 1974 when it established itself as the exclusive regulatory authority of employee benefits.

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245. Self-Insurance Institute of America, *New Mandate in Budget Bill Impacts Health Plans*, at <<http://www.siaa.org/htdocs/whatsnew/>> (collected on August 12, 1999, on file with the Buffalo Law Review).

246. See *The Women's Health and Cancer Rights Act of 1998*, P.L. 105-277, 112 Stat. 2681 (1998); see also Self-Insurance Institute of America, *New Mandate in Budget Bill Impacts Health Plans*, at <<http://www.siaa.org/htdocs/whatsnew/>> (providing date of the signing) (collected on August 12, 1999, on file with the Buffalo Law Review).

247. See Ann Winslow, *The Financing of the U.S. Health Care Industry*, HARV. BUS. SCHOOL, No. 196-095 (1995). "The federal government stipulates the minimum health services that the states must provide under Medicaid. They include inpatient hospitalization, outpatient hospital services, services at rural health clinics, laboratory and x-ray tests, SNF care, physician services, home health care, nurse-midwife services, and pediatric nurse practitioners." *Id.*